IAS The Irish Association of Suicidology

NATIONAL SUICIDE REVIEW GROUP

# SUICIDE PREVENTION IN SCHOOLS

# BEST PRACTICE GUIDELINES

# MEMBERSHIP OF WORKING PARTY


Ms. Myra Barry, Chairperson & Co-Author,
Senior Clinical Psychologist, Child & Family Centre,
Director IAS,
Castleknock Road, Castleknock,
Dublin 15
Phone: 01 821 4245/4385/2103
Fax: 01 821 7047

Mr. Billy Bland, Co-Author
Suicide Resource Officer,
Health Promotion Office,
The Old Maltings, Coote St.,
Portlaoise, Co. Laois
Phone: 086 8157320
0502 64513
william.bland@mhb.ie

Ms. Ella Lovett, Co-Author
Senior Clinical Psychologist,
Beechpark Outreach Service,
Northside Team, 1st Floor Offices,
102 Malahide Road, Fairview, Dublin 3
Phone: 01 832 9257/58/61
Fax: 01 832 9256
bpnorth@eircom.net

Ms. Teresa Mason, Co-Author
Suicide Resource Officer,
Health Promotion Department,
15 City Gate, St. Augustine St.,
Dublin 8
Phone: 01 670 7987
Fax: 01 6707978
hpd@eircom.net

Ms. Carmel McAuliffe, Co-Author
Research Psychologist,
National Suicide Research Foundation
1 Perrott Avenue, College Rd, Co. Cork
Phone: 021 4277 499
Fax: 021 4277 545
nsrf@iol.ie

Mr. Barry McGale, Co-Author
Suicide Awareness Co-ordinator,
Health Promotion Department,
Westcare Business Services,
12c Gransha Park, Derry, BT47 6WJ
Phone: 048 71865127
bmcgale@westcare.n-i-nhs.uk

Ms. Eileen Williamson, Secretary & Co-Author
Programme Manager, N.S.R.F.
Director, IAS.,
National Suicide Research Foundation,
1 Perrott Avenue, College Road,Co. Cork
Phone: 021 4277 499
Fax: 021 4277545
nsrf@iol.ie

Ms. Margaret Horgan, Consultant
Parents Representative,
Trien, Kilmorna, Listowel, Co. Kerry

C/O NPC PP
Marino Institute of Education,
Griffith Avenue, Dublin 9
Phone: 068 45100
087 2319246
npcpp@gofree.indigo.ie

Mr. John Lahiff, Consultant
National Co-ordinator SPHE,
Marino Institute of Education, Griffith Avenue,
Dublin 9
Phone: 01 8057718/96
sphe@mie.ie

Ms. Anne Moore, Consultant
Guidance Counsellor, Gonzaga College,
Sandford Road, Ranelagh, Dublin 6
Phone: 01 4972931

Ms. Majella O' Shea, Consultant
School Principle,Colaiste Lorcain
Castledermott Co. Kildare
Phone:0503 44167

Dr. John Connolly
Editor and Co-Author
Hon. Secretary, IAS,
St. Mary's Hospital
Castlebar,
Co. Mayo.
Tel +353 94 42084
Email drjfc@iol.ie



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# INTRODUCTION

These guidelines grew out of our concern about suicide in young people and the requests from schools and teachers for information and guidance on how to cope with a pupil who is distressed and threatening suicide. In addition many requests for information on how to cope with the suicide of a student, a teacher or other member of staff, and its aftermath were received. Unfortunately many schools have had such an unfortunate experience. A multidisciplinary committee was formed under the chairmanship of Myra Barry, a director of the Irish Association to research the literature on the subject and draw up a set of guidelines on Best practice in suicide prevention in schools in consultation with all the parties interested and involved in this subject.

At a major conference in Galway on 'Suicide Prevention in Schools', December, 2001, run jointly by the Irish Association of Suicidology and the National Suicide Review Group, many of the issues involved were aired and discussed in detail and taken into consideration when developing these guidelines. In addition a consensus statement on the subject arose out of discussions at that meeting which has been developed and updated and will be presented to the Department of Education and Science and the Department of Health and Children later this year for action. The Consensus statement can be found as an appendix to this booklet.

Everyone is aware of the increasing rates of suicide in Ireland particularly among men, in the age range 15-24, among whom it is the leading cause of death. Suicide is an unnecessary death, yet our understanding of why it happens or why a particular individual chooses to die rather than live is very poor. Suicide is impossible to predict except perhaps in acutely disturbed people in the short term. The risk factors for suicide merely tell us what the characteristics are of a group of people who have already died by suicide and are not in themselves predictive of suicide. We must remember that suicide is a rare event even in high-risk groups and accounts for between 1 – 1.5 of all deaths in Ireland in any given year.

Suicide prevention is not an exact science and has many strands to it from limitation of access to means of taking ones life to education in life skills and problem solving skills. The most important initiatives in suicide prevention will probably prove to be the introduction of broad based programmes such as the SPHE and others, e.g., Mental Health Matters, the value of which is to facilitate students in developing life skills. All of these must be considered in suicide prevention in schools as should the creation of the truly health promoting school. In addition the implementation of a national alcohol policy and a change in our attitude to alcohol will prove very important. In various ways the consumption of alcohol and alcohol abuse are highly associated with suicide and the educational system is the ideal place in which to begin to change this.

There is some controversy about suicide prevention programmes in schools as set out in section three of these guidelines. The interventions mentioned in these guidelines with there strengths and weaknesses are not mutually exclusive. Together they form an integrated approach to all aspects of suicide prevention - primary prevention, intervention and postvention. The limitations of all such interventions must always be kept in mind. What is clear is that once off lectures or seminars on suicide to students are of little use and are likely to cause harm.

Suicide prevention, which is every bodies business, is a complex issue and the approach to it must be consistent and based on robust research. All of us have a role in this enterprise. These guidelines are no more or no less than that. Their aim is to create a framework for the implementation of a workable suicide prevention programme by creating awareness of the issues involved and build up support networks. We introduce them mindful that while teachers have a role to play in suicide prevention the guidelines will not turn them into experts on the matter nor are they intended to do so. Likewise we are aware of the staffing implications of a comprehensive suicide prevention strategy and the existing burdens on teachers. Suicide prevention will need the employment of many more educational psychologists and school guidance counsellors. There are also implications for staffing levels in the Health Boards and other community agencies. Later this year we will present our guidelines to the government and address theses and other matters.

The guidelines were developed following a great deal of consultation with teachers and their professional organisations, parents' organisations and various experts in the field as well as an extensive review of the international literature. A list of further reading can be found in appendix. Following publication we hope to hold a series of workshops to help with the implementation of a suicide prevention strategy in schools. The guidelines will be subject to continuous review and revision in the light of the experience in implementing them and for this reason comments on their usefulness and shortcomings are welcome.

We take this opportunity to thank all the members of the committee for their dedication and hard work over the past eighteen months. A special thanks is also due to all of the people and agencies who took part in the oral and written consultation process. We hope that the Guidelines will prove to be a valuable resource to all involved in suicide prevention.

*MYRA BARRY,*
*JOHN F CONNOLLY*

# SECTION I:

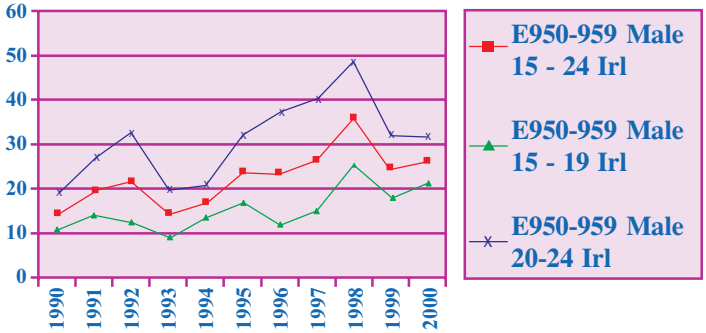
# INTRODUCTION

While suicide is a rare behaviour accounting for 1% of all deaths in Ireland and Northern Ireland, a worryingly large proportion of these are young males. In 2000 suicide was the leading cause of death among 15-24 year olds in Ireland. Of the 105 suicides in this age group in the Republic of Ireland , 84% were male, while in Northern Ireland 78.6% were males.

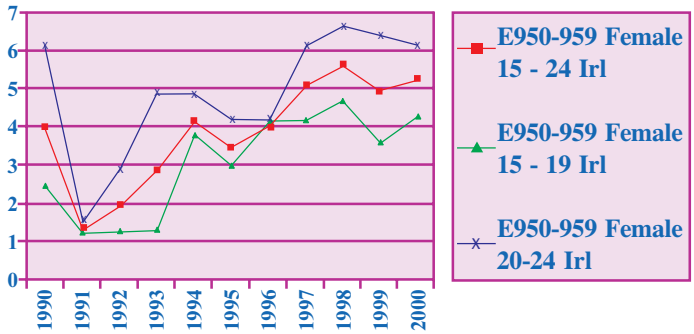
The most striking trend in suicide rates the Irish Republic since 1976 has been the fourfold increase in the 15-24 year-old male suicide rate from 7 to 26.2 per 100,000 reaching a peak of 36.0 in 1998. In the same period in Northern Ireland the rate for males in that age group increased from 8.6 to 30 per 100,000. The increasing rate in this group has been noted in most industrialised countries. For the Republic of Ireland it led to a situation in the 1998 where young males were seven times more likely to die by suicide than their female counterparts. Recent years have seen the suicide rate in 15-24 year-old Irish females more than double, albeit the rate is still low (4.8 per 100,000).

Graphs 1,2,3 and 4 illustrate the changes in the rates of suicide for males and females aged 15-24, 15-19 and 20-24 from 1990 to 2000 for Republic of Ireland and Northern Ireland.

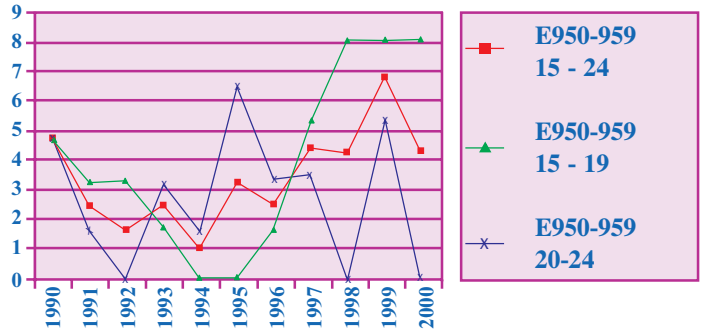
## GRAPH 1 — REPUBLIC OF IRELAND MALE SUICIDES AGES 15 TO 24



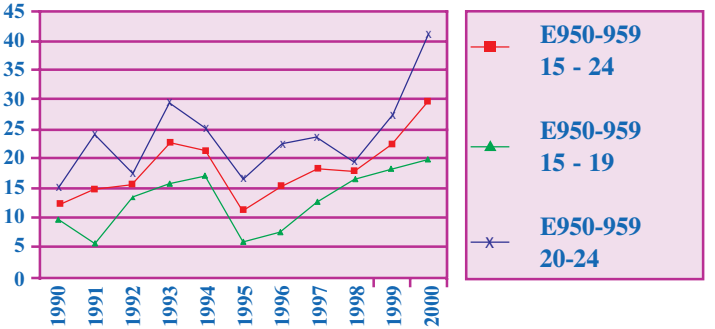

## GRAPH 2 — REPUBLIC OF IRELAND FEMALE SUICIDES AGES 15 TO 24



## GRAPH 3 — NORTHERN IRELAND FEMALE SUICIDES - AGES 15 TO 24




## GRAPH 4 — NORTHERN IRELAND MALE SUICIDES - AGES 15 TO 24




The incidence of suicide in those under 15 years of age though rare - is also significantly higher among males. Of the twenty-one suicides in age range 5 to 14 registered in Ireland between 1995 and 1999, eighteen were male. The dramatic increase in suicide rates after 15 years of age is thought to be associated with changes at puberty and the increased prevalence of mental disorder at this stage.

Parasuicide is ten to twenty times more common than suicide. It comprises non-fatal acts of deliberate self-harm and attempted suicide, including interrupted acts. Up to half of all cases of hospital-treated parasuicide in Ireland are by those aged under 25 years. Females aged 15-19 and males aged 20-24 are at highest risk for parasuicide.

Suicidal thoughts are particularly common in young people. In a study of second-year students in West Dublin, 29% reported having suicidal ideation at some point in their life. In the same study 2.3% percent reported episodes of self-harm. Similarly, in a study of 328 third-level students in Ireland, 32% reported a lifetime history of suicidal thoughts, while 6% had thoughts that

included a fairly detailed plan, with only 2% of the sample ever having engaged in self-harm. This indicates that while suicidal thoughts are common among young Irish people in education, overt deliberate self-harm is considerably less so.

When thoughts of suicide are accompanied by high levels of feelings of hopelessness about the future and a diminished range of coping skills, there is a significant risk of acting on these thoughts and attempting or completing suicide. Suicidal thoughts allied with a plan are an important risk factor for suicide in adolescents, even in the absence of mental disorder.

## SUICIDAL BEHAVIOUR: RISK AND PROTECTIVE FACTORS

Suicide risk is a balance between risk factors and protective factors. Suicide is a rare event even in high-risk groups and is almost impossible to predict. Risk factors are the characteristics of a group of people who have taken their own life. While there presence increases the possibility or likelihood of suicidal behaviour they are not predictors of suicide in any individual. Protective factors decrease the risk of such behaviour.

In assessing the risk of suicide, the number and severity of risk factors have to be weighed against the presence of important protective factors. Some important risk factors are presented below with their corresponding protective factors. The lists are by no means exhaustive, nor are they meant to represent actual suicide risk mechanisms.

| RISK FACTORS | PROTECTIVE FACTORS |
|---|---|
| History of suicidal behaviour | Prior experience of self-mastery and 'success' |
| Mental illness | Good mental health. Early detection, assessment and treatment |
| Alcohol/drug abuse | Healthy socialising and coping strategies. Early detection, assessment and treatment |
| Poor problem solving skills | Good problem solving skills, high self-efficacy |
| Relationship problems & loneliness | Warm accepting relationships with family or friends |
| Impulsivity | Restriction of method availability |
| Early school leaving | Remaining in education |
| Unemployment | Employment |
| Suicide/parasuicide in a family member/ relative/friend | Postvention procedures |
| Negative approach to help-seeking | Healthy approach to help-seeking based on interdependence |

## RISK & PROTECTIVE FACTORS: AN OVERVIEW

### History of suicidal behaviour

Past suicidal behaviour is a significant risk factor for future suicide attempts and suicide. Those who have engaged in deliberate self-harm in the past are more likely to repeat the behaviour, as it becomes part of their coping repertoire. Up to one-in-five individuals treated in hospital for parasuicide repeat within six months and one percent complete suicide within that time. Suicide attempters are also approximately 10 times more likely to die eventually by suicide.

Threats or hints about self-harm are an important warning signs and should always be taken seriously. as the majority of people who take their own lives have a history of suicidal ideation.

### Mental illness

Mental illness is also an important risk factor for suicidal behaviour. Approximately 90% of all suicides exhibit symptoms of mental illness, most commonly depression, although psychiatric disorder seems to be less common in young suicides.

Approximately one-third of parasuicides are diagnosed as suffering from some form of mental illness. This most commonly involves an abnormal response to stress, indicating that an external stressor may be the major precipitant to a non-fatal episode, rather than the mental illness. An interpersonal problem is the commonest trigger for parasuicide. Loneliness – whether real or perceived - is widely reported in this group.

### Alcohol/drug abuse

Abuse of alcohol is an important risk factor for three reasons: Firstly, because it acts as a depressant; secondly, because intoxication impairs problem solving ability; and thirdly, because it increases the likelihood of acting impulsively on suicidal thoughts. Alcohol abuse is particularly significant among males, and in a recent study it was present in just under half of the male suicides. In a follow-up study of 245 self-poisoners in Ireland, 70% of males and 18% of females were classified were found to be suffering from alcohol abuse. Approximately half of male parasuicides and one-quarter of female parasuicides are intoxicated at the time of their attempt.

Drug abuse is also associated with depression, suicidal behaviour and suicide. Increased drug use among young people is thought to be associated with the rise in this age group, although it is acknowledged that its effect on young males may be particularly detrimental because of other risk factors, such as difficulties with seeking help.

### Problem solving ability

Significant problem-solving difficulties have been found among parasuicides when compared with psychiatric patients without a history of parasuicide and persons without psychiatric disorder. Problem solving ability involves competencies in generating and selecting effective solutions, and protects against other less adaptive responses, such as alcohol or drug use, which are in themselves risk factors for self-harm. Poor problem solving is also associated with hopelessness about the future.

It is recommend that preventive strategies be directed at bolstering protective factors in young people, such as interpersonal and coping skills and peer relationships. The introduction of Social, Personal and Health Education programmes (see Section II) in primary and secondary schools aims to help students to develop skills for self-fulfillment. The National Task Force on Suicide (1998) has advocated these programmes.

### Impulsivity & Method Restriction

While the association between impulsivity and suicidal behaviour is not clear, it is thought that impulsivity becomes important when lethal methods of suicide are readily available. Reducing access to methods of suicide has been idenitifed as an important and evidence-based strategy in suicide prevention. Limiting acces to means as a strategy in suicide prevention will only make an impact on suicide rates in general if the methods in question are commonly used and easily restricted.

### Sexuality, Suicide Risk

Most young lesbians and gay men became aware of their sexuality before the age of 15, when they would be in a school environment. Over half experience problems at school because of their sexual orientation and leave as a result. Many of them experience bullying and physical violence. Various international studies have found that there is a relationship between suicide attempts and homosexuality. A recent US study suggests that young gay men are seven times more likely to attempt suicide, and young lesbians two and a half times more likely to attempt suicide than their heterosexual counterparts. Opportunities in the school environment to support those who are, or who are perceived to be, lesbian, gay or bisexual need to be developed.
Methods of Suicide.
Unfortunately, hanging is the most commonly used method of suicide in Ireland among males and females aged under 25, and leaves little scope for eliminating access.

Drowning is the second most commonly used method in the this age group swimming education has been recommended as a preventive measure in the report by the National Task Force on Suicide (1998). Access to water cannot be restricted.

In Ireland firearms account for X% of suicides. They are more commonly used by males aged 15-24 than any other age group in Ireland. This is important given that in the United States, the availability of a loaded gun has been identified as one of the most important risk factors for youth suicide among those without a mental illness and their restriction has become a preventive priority there.

Self-poisoning is less common as a method of suicide in those aged 15 to 24. However, Europe-wide research has found that it is by far the most frequently used method in non-fatal deliberate self-harm (parasuicide). UK studies report a second consecutive yearly decrease in 1998 in the proportion of non-fatal overdoses involving paracetamol in the UK since the introduction of legislation to reduce paracetamol and salicylate pack sizes and to introduce blister packs. In Ireland, the National Task Force (1998) recommended that restriction of the sale and supply of paracetamol in shops and chemists be made a statutory regulation under the Irish Medicines Board Act, 1995. This regulation came into force in October 1st 2001.

### Early school leaving & Unemployment

Early school leaving has a complex relationship with suicidal behaviour. It is associated with exposures to numerous other risk factors such as coming from backgrounds of low socio-economic status, violence in the home, family difficulties, engaging in drug taking and other risk-taking behaviours. In an Irish context, being in education is protective against suicide. Unemployed males are at increased risk of self-harm. A significant finding from an examination of suicide rates in Irish males aged 15-24 between the years 1976-1993, is that students had the lowest rate of suicide, while the non-student unemployed had the highest rate.

There may be many reasons for this protective influence, including access to peers and other social supports and services, along with structured routines and discipline, all of which a school provides. Education is also protective against parasuicide. In particular early school leaving is a risk factor for males. In a longitudinal study of self-poisoners in Cork city, 85% of the males had left school at the minimum age in comparison with only 5% of the females.

### Suicide/parasuicide in a family member/relative or friend

Of all age groups young people are most vulnerable to imitation (often referred to as copy cat suicide or suicide contagion) following a suicide or attempted suicide. Adolescents in particular learn by modeling the behaviour of those around them. The concept of suicide clustering is not clearly established and while suicide clusters are more common among adolescents and young adults than any other age group, only 5% of all teenage suicides in the US may be accounted for by clustering. However the perception of a suicide cluster within a community may itself be a risk factor for suicide. This in itself necessitates a timely and appropriate response plan within the school community, targeting those who are at highest risk of suicide.

## POOR HELP-SEEKING ABILITY

Poor help seeking ability in males in terms of service usage has also been identified as a risk factor for suicide. In a study of 100 suicides it was found that less than half of the males (41%) under 29 years old had been treated for psychiatric illness by a general practitioner or a psychiatrist in the year before death. Only 7% had been treated in the month before death. In contrast, females in all age groups were far more likely to have received medical treatment.

Closely allied to service usage is knowledge of services, which also appears to be lacking in young people. A study of 93 Irish university students found that almost half did not know where they would turn if they were in trouble. In addition, none of the students mentioned general practitioners or local medical services and only one mentioned a private psychiatric service. Consequently, the development of services that are accessible and acceptable to young males in particular is vitally important. In a study of 45 West Dublin secondary level second year students, only eight suggested professional counseling for someone who was talking of killing themselves, while only seven suggested psychiatric help.

## CONCLUSION

In 1996 74% of 15-19 year old males and 82% of their female counterparts were in full-time education. Given the rapid increase in young male suicide, the more recent increase in female suicide, and the fact that half of all parasuicides in Ireland are aged under 25, schools and colleges have an extremely important role to play in suicide prevention.

Addressing the multiplicity of risk and predictive factors associated with youth suicidal behaviour, as outlined above, requires input from all levels of the school system but also depends on the school's links with the wider community. Education is protective against suicide and parasuicide, which suggests that schools are already playing a role in suicide prevention. As youth are the most vulnerable of all age groups to imitation of suicidal behaviour, schools need to develop policies and procedures for dealing with these situations well in advance of crises.

# SECTION II:

# PREVENTION OF SUICIDE IN THE SCHOOL SETTING

## INTRODUCTION

The development of school policies to support suicide prevention in advance of a crisis is of vital importance. Valuable opportunities for prevention have often been missed in the early stages of a community's response to a suicide when community leaders had to search for information on best practice in preventing a suicide cluster or copycat suicides.

A school policy will be required as a guideline for action and to outline the responsibility of teachers concerned about the emotional health or even suicide risk of a student. Schools and health services also need to develop linkages in advance of these crisis times.

The success of all suicide prevention initiatives in the school is dependent on agreed procedures and routines and this fact is highlighted in the literature. Schools should also put in place policies that will impact on the general health and safety of students and staff, such as anti-bullying policies, alcohol and substance abuse policies. It should also be noted that the process of developing a policy is as important as the final written document as this gives ownership of the policy to those involved.

These guidelines provide a framework for the development of a policy to address the issues of suicide prevention and the promotion of the mental health of students the three areas of primary prevention, intervention and postvention. The policy document should also include a description of how the ethos of the school supports these activities.

**Prevention**: The activities that the school undertakes on a regular basis to promote the mental health of its students and to ensure that its staff have the requisite skills and abilities to deliver programmes and recognise mental ill heath or distress in their students. It should also include a statement of how it proposes to support students with mental health difficulties within the school environment.

**Intervention:** A written statement on how the school approaches the management of investigating the extent of a students distress, expressed suicidal thoughts by a student and how incidents such as self-injurious behaviour and attempted suicide are managed. It should include a clear chain of communication for staff to be aware of to encompass linking with parents and outside agencies. The extent of appropriate confidentiality should also be set out.

**Postvention:** A plan of action for the containment and management of traumatic deaths within the school community, including suicide, should be negotiated and written in advance of the possibility of such unfortunate circumstances. Clear descriptions of responsibility for individuals such as the principal and a crisis team would be outlined in this crisis plan.

### EVALUATION

For the development of best practice, any intervention, response or policy needs to be evaluated and updated regularly. The design of evaluations of activities should ideally be considered in the planning phase for the intervention. The conclusions drawn from evaluating an initiative will help to inform future planning and the refinement of the policy in response to the unique needs of the school.

## NEEDS A HEADING?

Primary prevention of suicide in the school setting encompasses a wide range of activities intended to develop protective factors against suicide. These are targeted at the main student body but teachers and parents may also be the focus of initiatives. These activities are sometimes termed primary prevention and can be conceptualised as two main areas, the first of which is a broad based approach, with a mental health promotion focus while the second has a suicide-specific agenda

The majority of the controversy exists about the latter category. However the reality is that many schools have experienced the tragic death of a student or indeed a member of staff through suicide. Therefore some knowledge about groups and individuals at risk and of the warning signs impending suicide is essential for all involved. However it is important to realise that once off seminars or lectures for pupils on the topic of suicide are of little value and are probably harmful. Suicide prevention involves has many elements and needs a broad based integrated approach. A number of initiatives are described here with a short description of each including the strengths and weaknesses of each approach. The initiatives are not mutually exclusive rather they are complementary and can be integrated into a unified approach to suicide prevention.

We are mindful of the staffing implications for the implementation of these guidelines both for the school and for the health authorities and other helping agencies.

## INITIATIVES WITH A MENTAL HEALTH PROMOTION FOCUS

The initiatives described in this section have a broader focus than suicide. The activities described are:

1. The Health Promoting School
2. Social and Personal Health Education Programmes
3. Peer Support Programmes
4. Issue Based Education
5. Initiatives with a Focus on Suicide

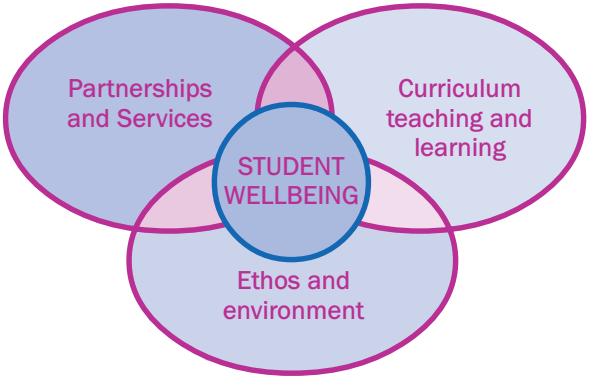
### 1. The Health Promoting School

This approach takes an ecological view of the school as an environment in which to influence the health of all the individuals. The importance of linkages with the community is also emphasised. A team within the school works to enhance the capacity of the school to impact positively on health.

Description: The Health promoting school develops the physical and social qualities of a school that affect how staff and students feel and behave while they are there. The characteristics of the health promoting schools are:

- Shared school goals and vision
- Continuous academic and social growth
- Extensive communications with opportunities for input
- Mutual respect
- High level of trust

- Caring and acceptance
- Clearly defined and consistently applied discipline
- Play and humour
- Strong sense of ritual and tradition
- Pleasant and stimulating environment




**Strengths:** It encompasses both the development of personal and social skills, communication skills and help-seeking skills in the school curriculum and the development of a more supportive school community.

**Weaknesses/ Difficulties:** it can be viewed as an abstract and nebulous concept for schools to take on board with so many other competing demands.

2. Social and Personal Health Education (SPHE)

The aims of Social and Personal Health Education (SPHE) are:

- To enable the students to develop generic skills for self-fulfilment and living in communities
- To promote self-esteem and self-confidence.
- To enable the students to develop a framework for responsible decision making
- To provide opportunities for reflection and discussion
- To promote physical, mental and emotional health and well-being.

Structure of SPHE:

In the SPHE programme the young person will deal with a wide range of issues. It is described as enabling curriculum giving schools discretion to focus on the needs of pupils at local level. In the primary school setting the issues may be introduced in three strands and ten strand units.

| Strand | Strand units |
|---|---|
| Myself- self identity | Self-identity<br>Taking care of my body<br>Growing and changing<br>Safety and protection<br>Making decisions. |
| Myself and others | Myself and my family<br>My friends and other people<br>Relating to others |
| Myself and the wider world | Developing citizenship<br>Media education. |

In the post-primary school setting the curriculum for SPHE in the junior cycle is presented in ten modules, each of which appears in each year of the three-year cycle.

| Module | Topic areas |
|---|---|
| 1. Belonging and integrating | Group skills, responsibilities within groups, family and school as groups we belong to. |
| 2. Self-management | A sense of purpose- study skills, work schedules and teamwork. |
| 3. Communication skills | Listening and communicating effectively. Managing conflict. |
| 4. Physical health | Hygiene, nutrition, exercise and common ailments. |
| 5. Friendship | Good friends, changing friends, dealing with difficulties such as bullying. |
| 6. Relationships and sexuality | Skills for communicating and making decisions in relationships, conflicts, stereotyping, understanding adolescence, reproduction and birth, respect, rights, responsibilities. |
| 7. Emotional health | Recognising and respecting feelings, expressing feelings, stress management. |
| 8. Influences and decisions | Forward planning, who and what influences us, respecting individuality. Making decisions and implementing them. |
| 9. Substance use | Medicines and drugs, smoking and alcohol, harmful drugs and their effects. |
| 10. Personal safety | Keeping safe, road, fire and personal safety. Help agencies. |

**Description:** The emphasis in SPHE is on building skills, understanding, attitudes and values in an integrated way relevant to a range of social, personal and health issues.

**Strengths:** there is extensive research evidence to illustrate effectiveness in promoting mental health. Problem solving skill training and self-efficacy enhancement for adolescents may be the more effective in suicide prevention than giving students information about suicide per se. The National Task Force Report on Suicide in Ireland advocated this generic approach and much of the literature on addressing suicide in the school setting makes the point that the single-issue education program on suicide prevention is inappropriate. The SPHE programme will be implemented in all post – primary schools in Ireland by September 2003.

**Weaknesses/ Difficulties:** there is evidence to suggest that such a programme is best taught through participative methods. Teachers require on-going support and training to facilitate this programme. It is possible that such an education programme is counter-productive unless it is delivered in the context of a supportive school environment, which is health promoting.

### 3. PEER SUPPORT PROGRAMMES

These programmes are designed to help students to develop peer-helping skills.

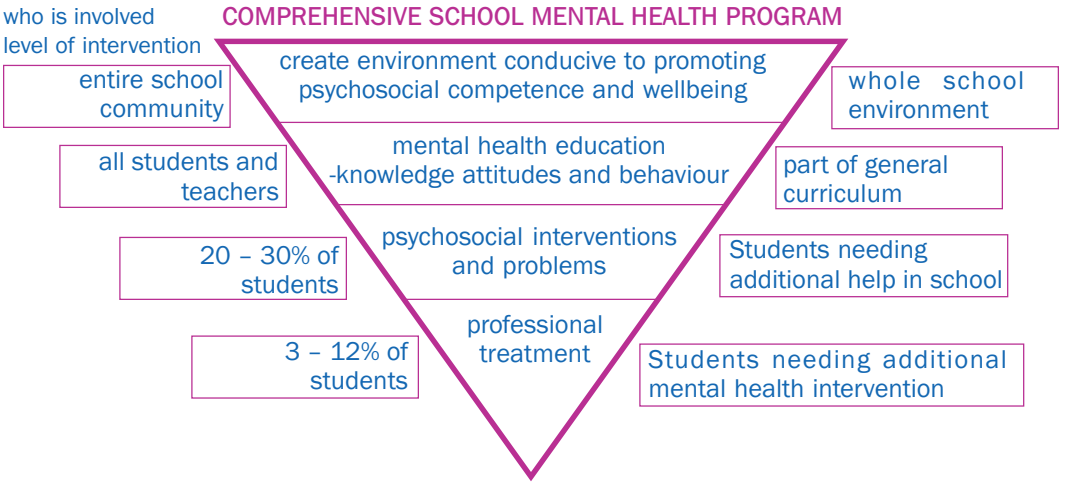
**Description:** training young people in helping and communication skills and imparting knowledge to their peers.

**Strengths:** the rationale is that youth in distress will more readily confide in their peers and will be more willing to accept health information from someone they don't perceive as an authority figure. Programmes are particularly useful if they focus on skill development and not purely on transmitting information.

**Weaknesses/Difficulties:** peer helping is an onerous responsibility to place on any young person who may not be adequately prepared or mature enough to deal with serious problems. With such programmes there is a need for clear boundaries. Students can only provide a low level of support and raise the alarm when more serious issues arise. A strict emphasis should be placed on referring students to the adults in the school counselling services when serious issues or concerns arise. Peer support programmes will require good training and a support system for students. The focus of peer helping should be on training young people to become peer supports, not counsellors, and their roles limited to academic and developmental issues. Peer helping should be seen as an extension of school counselling programs. Some schools may not have the necessary resources or back up support structures to provide such programmes.

### 4. ISSUE BASED EDUCATION

Issue Based Education that aims to educate students about mental health and social issues so as to encourage greater awareness. The schools pack Mental Health Matters produced by Mental Health Ireland (formerly the Mental Health Association of Ireland) is an example of one such programme.




*Adapted from World Health Organisation, 1994*

**Description:** programmes that provide education about mental health issues, mental illness, alcohol and drug abuse and social problems.

**Strengths:** mental health awareness programmes have reported more positive help-seeking attitudes

**Weaknesses/ difficulties:** a didactic approach, if used, is weak at changing attitudes
Skill based education is more effective at preventing substance abuse than giving information about the harmful affects of drug use.

## 5. INITIATIVES WITH A FOCUS ON SUICIDE

The activities described in this section are:

A. Suicide awareness training for school staff including training in coping with the aftermath of a suicide
B. Suicide awareness programmes for parents, guardians and the community
C. Suicide awareness programmes for students
D. Screening

### A: Suicide Awareness Programmes for School Staff

**Description:** designed to help school staff identify students at risk and to refer them for help by providing training for adults in awareness of suicide.

**Strengths:** evaluations show increased knowledge, favourable attitudes and increased referrals. Other benefits may be increased awareness of stresses in the school environment that can be tackled and changed.
**Weaknesses/ Difficulties:** two potential negative consequences should be guarded against in implementing school gatekeeper training programmes. These are staff sensitivity towards students about being singled out and the danger of overloading stretched services with inappropriate referrals.

**Note:** There may be merit in broadening staff training to encompass mental health difficulties rather than solely focusing on suicide, given it is a relatively rare event.

B: Suicide Awareness Training for Parents, Guardians and the Community
**Description:** There is little information in the literature regarding suicide awareness training for parents as a single group. Such training usually evolves from a local community suicide prevention strategies, often referred to as 'Gatekeeper training programmes', which target the general public, or as part of a local school suicide prevention initiative incorporating training for both school personnel and parents. This way of community involvement could an important strand of the health promoting school concept.

**Strengths:** These programmes have similar objectives to those that focus on teachers i.e. increasing knowledge about suicide risk and willingness to intervene to arrange appropriate help for the young person but also have a focus on involving parents and developing interagency cooperation and improved knowledge of services. Participants are usually positive about these programmes and can show increased knowledge and willingness to become involved in helping an at risk individual.

**Weaknesses:** Training is dependent upon having adequate resources and personnel in place for delivery. This training will be less effective if it is not linked with other initiatives and agencies in the local area. With suicide prevention a broad and comprehensive approach with multi-agency involvement is essential and recommended.

C: Pupil Awareness Programmes
**Description:** These programmes are designed provide suicide awareness training for students.

**Strengths:** Some programme evaluations demonstrated effectiveness in:
Changing attitudes and improving knowledge about suicide, helping students to select appropriate resource persons and increased referrals to local services by peers.

**Weaknesses/Difficulties:** the accuracy in programme content. Some programmes have the potential to normalise suicide and may encourage imitation.
The potential to cause guilt if adolescents are unable to assist their peers.
Questions about the safety of programmes for those most vulnerable to suicide.
Awareness programmes have limited effect in changing attitudes.
Programmes have not been shown to alter the level of suicidal thoughts and may not reach high-risk adolescents who are often out of school.

### D: Identification of Those at Risk

The main aims of school-based education and procedures are to heighten awareness of the problem and to promote case finding. In addition these programmes provide staff and students with information about mental health resources and improve teenagers' coping abilities.

**Description:** Early identification using questionnaires and follow-up assessments with those who score at a certain level of risk followed by referral to a case manager or school-based personal growth programme.

**Strengths:** The rationale is based on identifying those at risk and concentrating resources on them, given the fact that a great deal of clinical depression is undiagnosed.

**Weaknesses/Difficulties:**

No accurate screening tool has yet been identified which has both the necessary sensitivity and precision for efficiently identifying high-risk youth. Screening can result in many 'false positives' i.e. it may identify students who are not at risk of suicide. Screening also has the potential to stigmatise students.

While research in the United States advocates screening, in the context of the Irish education system, this approach is not recommended at present due to the fact that currently there is insufficient infrastructure and resources to support it.

# SECTION III:

# INTERVENTION IN THE SCHOOL SETTING

## INTRODUCTION

Intervention in this context relates to activities undertaken by a teacher when a pupil is in emotional crisis or is suspected to be at risk for suicide. Intervention is sometimes referred to as secondary prevention.

Assessing suicidal risk in young people is not part of the job of the teacher, however it would be useful for teachers to be aware of what situations may put a young person at risk and to be aware of some of the warning signs of suicidal behaviour. In addition teachers may find it helpful to have in mind, a framework of what to do when concerned about a young person, including what it might be appropriate to say and what may be less useful for students to hear. A good knowledge of what support is available to a teacher within the school environment and from the statutory health authorities is also necessary.

An understanding of the limitations of the support a school can offer to a young person and when outside professional help is indicated is also of the utmost importance. In these situations structures, which guide action or policies, are of vital importance for the teacher and the well being of the student. Training is also necessary for teachers to absorb this information and to discuss these emotive and complex issues.

The information covered in this section relates to:

- Identification
- Taking Action
- Referral

## IDENTIFICATION

In addition to identification of at risk students this section looks at possible risk situations, which may trigger suicide or suicide attempts, and at potential warning signs of suicidal behaviour.

While this information may be helpful in identifying students at risk it is important to note that knowledge of these signs and risk situations does not guarantee effective management of a crisis. A number of other considerations must also be addressed including school policy and the skill of staff in responding to the distressed or suicidal student.

## RECOGNITION OF STUDENTS AT RISK

The existence of the following symptoms may indicate a student in an at risk situation:

- Unexpected reduction of academic performance.
- Ideas and themes of depression, death and suicide.
- Change in mood and marked emotional instability.
- Significant grief or stress.
- Withdrawal from relationships.
- Physical symptoms with emotional cause.

## WARNING SIGNS OF SUICIDAL BEHAVIOUR

- Writing about suicide.
- Speaking about suicide.
- Listening to songs praising suicide.

- Art work about suicide.
- Threats and statements of intent.
- Preoccupation with a known suicide.
- Life threatening risk taking behaviour.
- Giving away treasured possessions

It is important to note that while the above signs are helpful in recognising students at risk, the list is not exhaustive, nor are they necessary for suicide risk. In many individual these warning signs are simply clues to the existence of more serious underlying risk factors.

## RISK SITUATIONS, WHICH MAY TRIGGER SUICIDE OR SUICIDE ATTEMPTS.

The focus here is on situations that may be experienced as injurious and lead to anxiety and chaos. Suicidal students perceive such situations as attacks on their self-image, and suffer a sense of wounded personal dignity. Situations, which may trigger suicide or suicide attempts, are:

- Separation from friends, girlfriend/boyfriend, classmates etc.
- Death of a loved one or significant other person
- Termination of a love relationship
- Interpersonal conflicts or losses
- Legal or disciplinary problems
- Peer group pressure and acceptance of self destructive behaviour
- Bullying and victimisation
- Disappointment with school results and failure in studies
- High demands at school during examination periods
- Unemployment and poor finances
- Unwanted pregnancy and abortion
- HIV infection or other STD infections
- Serious somatic illness
- Natural disasters

(WHO, 2000, Guidelines for Suicide Prevention Among School Pupils)

## TAKING ACTION

The following pointers are reproduced from A Leenars, A.A. **Helping Your Suicidal Student.** University of Leiden, Netherlands.

- **Believe it.** Accept the possibility that your student may be in danger. Take it seriously. Do not deny the possibility because children and teenagers do kill themselves.

- **Check it out.** You may want to check with another person e.g. the principal or parent, to see if he/she shares your opinion. Parents may be a good source of information. Often parents and other students know what you are only beginning to believe. You may ask the child directly if he/she is thinking of killing himself/herself and tell them about the clues you have noticed. Suicidal students are often relieved to find someone willing to talk. Don't be afraid that you are putting the thought into his/her mind, even with a child.

- **Be calm.** Don't panic it will only increase the students perturbation and may jeopardise your own ability to act.

- **Listen.** Take the time to listen to your student. Encourage your student to verbalise his/her feelings and thoughts. Accept what he/she says without judgement. Don't make false promises that things will get better immediately.

- **Show you care.** Make it clear to your student that you understand and that you are really concerned. Let the child know that you care and want to help in a sound supportive fashion. Make yourself available.

- **Do not say** something like: "That is stupid. How could anyone be so silly as to think about killing themselves?

- **Do say** something like: "Tell me more about your feelings so that I can help".

- **Do not** leave the student alone

- **Get help.** Get professional help. If he/she refuses help you should initiate it yourself. Contact the parents, the principal, and a professional. Meanwhile if the risk of suicide is high, don't leave the student alone. Take the student with you along to a source of help or call a crisis centre to assist you with what you do. If the suicidal act is in progress call the ambulance and police immediately. It may be too late to act later if the student has taken some potential life threatening action.

  It is important to be honest with the young person and not to give false reassurances or try to make light of their distress because it makes you uncomfortable. Offering an opportunity to really listen to his/her perspective can be very helpful and provide some relief.

- Do not promise confidentiality. **Never make and keep a promise of confidentiality about the individuals' suicidal intentions. Suicidal thoughts are one secret that should not be kept.**

- Seek help. **It is important to remember that you do not have to manage concerns about student's welfare or mental health alone. Sources of help available in the school may be other staff, nurses, counsellors, pastoral care or chaplain.**

- **Contact parents, guardians and families.** Children and teenagers are often best helped by providing information and support to those closest to them.

  For majority of parents and guardians suicide and suicidal behaviour is something, which is outside the normal range of experience. Parents therefore often feel reassured if they know that the school are prepared and have a plan of action and know what to do and who to contact.

  Some parents may be suspicious of receiving help from statutory services or may be too distressed themselves to organise and arrange help. Teachers, therefore, are very often

expected to play a leading role in organising help and support.

For students at risk of suicide parents or guardians need to be informed of the teachers concerns and the circumstances surrounding their concerns as soon as possible. Arrange if practicable for the parents or guardians to come to the school, and if this is not possible a specific plan of action should be agreed with them.

The school or teacher if they believe the student is at risk should recommend referral to professional services for immediate assessment. The school should provide the parents with specific contacts and telephone numbers in their local region. Teachers should assist with making these contacts if necessary.

A nominated teacher should maintain contact with the parents or guardians throughout the process. The school needs to document what has occurred, what actions were taken, by whom, when, where and how and in keeping with principles of good practice.

## REFERRAL

In an emergency students who are suicidal or have attempted suicide should be referred by the school staff to appropriate professionals, including the family doctor, or to a hospital casualty department in accordance with the policy of the school. In Ireland the level of professional health services and resources can vary in different locations. The lack of resources and difficulties in accessing services is acknowledged, however health boards are addressing these issues and improvements are in train.
Decisive intervention can be lifesaving. Various forms of supervision, and the removal of means (such as firearms or dangerous drugs) from the school, parental home, and other premises are recommended. Psychological support should be offered simultaneously".

In other instances the decision of whether to refer a young person on to an outside service may not be so clear-cut. Again training and school policies can to some extent address these issues. It is important to be aware of your limitations in supporting a young person with emotional health difficulties as well as the unique position that a teacher occupies in terms of being able to influence positively the well being of a student.

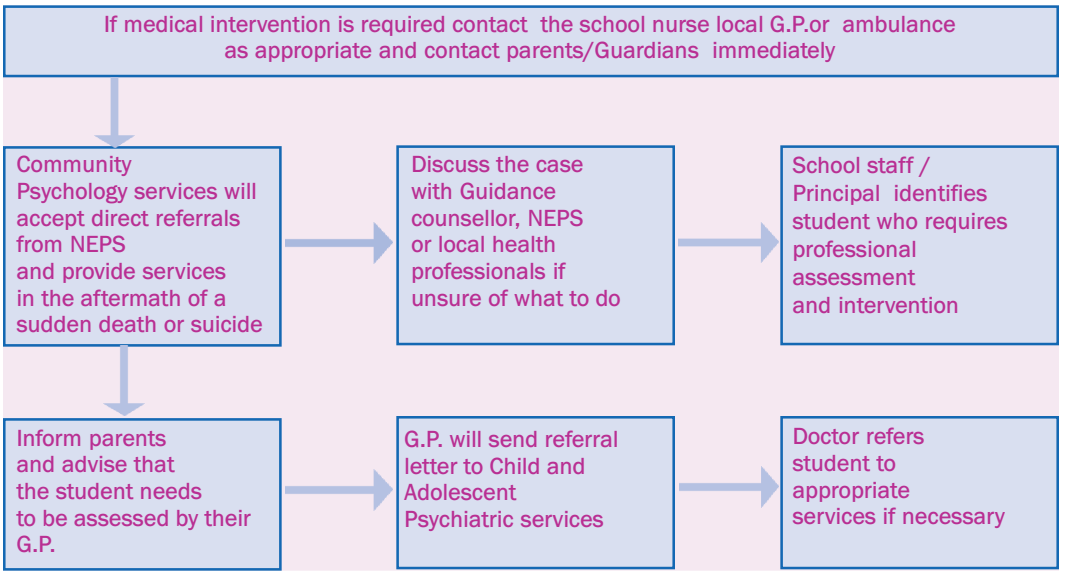
Linkages between schools and agencies such as general practitioners community care, social work departments and adolescent mental health services are of great importance. If a good two-way communication system exists, then ideally health services will be a source of help and support regarding appropriate referrals and where a level of trust exists some fast tracking or rapid service response may be possible. Similarly schools can provide an excellent source of support and information to health professionals involved in the care of young people in the school system.

The manner of referral will be dependant upon the nature of the problem and how acute the crisis is. In some cases quick and decisive action is what is required as this may prove to be life saving. While there is an understanding and expectation that schools and teachers will act re-

sponsibly in life threatening situations most schools do not have a clear and agreed policy on this issue. Some schools have permission from parents to act in “Locus Parentis” when the welfare of a student is under threat however in some less acute cases it may be more appropriate to seek permission or guidance from the parents as to the response required.

In terms of best practice schools may need to review current practice in relation to ‘locus Parentis’ with a view to developing more formal arrangements with parents which could be included in the schools crisis management plan. When there is a contingency plan for crisis situations (such as a student expressing suicidal ideation) in place in the school many potential problems and risk situations can be catered for and clear referral pathways can be outlined and agreed. If there is no pre-prepared contingency plan for handling a crisis the staff can contact the National Educational Psychology Service (NEPS) or Health Boards for advice.

As part of any contingency plan a list of local contacts should be obtained as a matter of course. This list should be regularly up-dated. This contact list can be attached to the staff notice- board or school handbook as appropriate and the office support staff should also have such a list readily available. These are some suggestions as to what contacts can be included however it is for each school to determine what contacts are appropriate.. It is important to consult with your local listed contacts in advance and seek their agreement to support your school in the event of a crisis, and to know what level of support they can provide. The list will be dependant upon what services and supports are available in the schools area.



As outlined in Section II two of this document it is important that protocols and policies for dealing with these interventions are in place well in advance of any emergency situation. The team must be aware of there roles in all aspect of the suicide prevention programme and have ownership of the school policy. Evaluation of the policy must be undertaken regularly and it must be updated regularly in the light of experience. Teachers must be aware of their limitations and not feel responsible for aspects of these interventions for which they cannot be expected have the requisite training. The best protection that one can have is knowing where to obtain help and assistance and forging good relationships with the helping agencies.

# SECTION IV:

# POSTVENTION PROTOCOLS IN THE SCHOOL SETTING

## INTRODUCTION

Postvention include those actities undertaken in a school or community following an adolescent suicide death or that of a member of staff. Ideally, the postvention package will operate in a climate where staff are aware of and are practising suicide prevention. There is a need to have a school policy for coping with other unexpected deaths such as those from road traffic accidents and natural causes so that all traumatic loss is dealt with in a standard framework.

The goals of suicide postvention are to

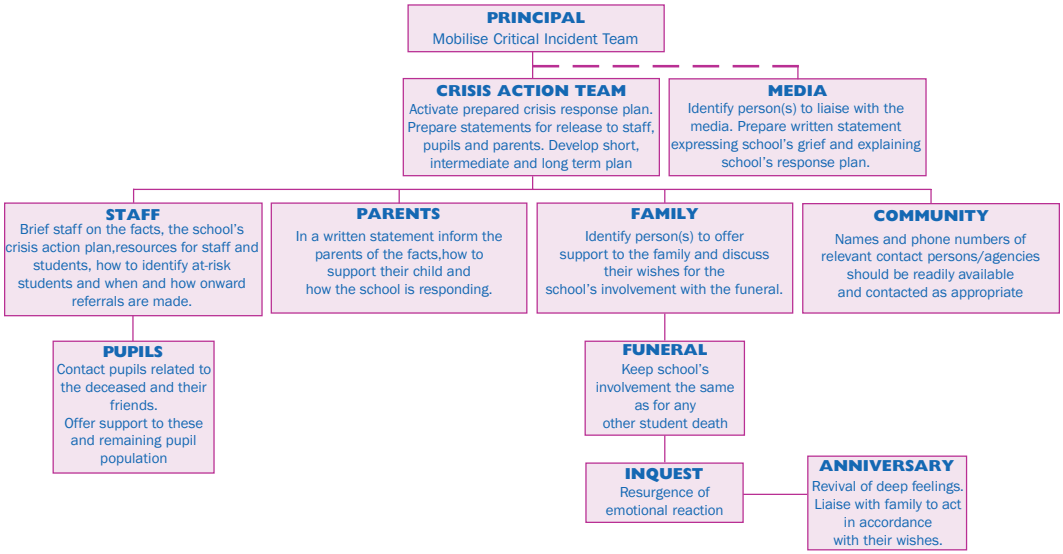
- Facilitate expressions of grief and mourning.
- Support the staff and students in the crisis in order to lessen the probability of developing psychological/physical disorders themselves.
- Prevent further suicides i.e. the possibility of copycat suicide.

A school can achieve these goals by putting in place administrative policies and procedures that allow the school to maintain the structure and order of school routine while at the same time facilitating the expression of grief in a controlled and organised way.

Understanding the process of grief should highlight the fact that although some of the feelings of grief may seem uncontrollable, the process of grief is not. When speaking to young people after a tragedy, it is a good idea to stress the normality of the grieving process and the anger and feelings of guilt that are a part of it. Teachers should talk of adapting to grief or learning to cope with it rather than recovering from it and they should not be afraid to show and share their own feelings.

## CRISIS ACTION PLAN

The key to coping with the crisis is planning. The school's response within the first 48 hours is crucial to the effective management of the situation. Research also indicates that the first three weeks following an incident is a time of great vulnerability for both staff and students.



Schools should draw up a policy and crisis action plan, which reflects their unique needs and culture. The strategies below are intended to help schools in the formation of their own policy and crisis action plan, by providing guidelines outlining the roles and responsibilities of the Principal and staff, the management of key relationships both within and without the school environment as well as the response of the school to particular events associated to the death. Below is a diagrammatic outline of a postvention plan.

## ROLES AND RESPONSIBILITIES OF SCHOOL PERSONNEL

### The School Principal

In the short-term the Principal is in a leadership role and in most cases is given the responsibility of managing the crisis and implementing the crisis action plan. As the crisis manager the Principal needs to:

- Confirm the death has occurred
- Mobilise the Crisis Action Team (see below) and prepare statements for release to staff, pupils and parents
- Brief staff after the death to outline the school's crisis response plan
- Designate persons to speak to the media on behalf of the school
- Designate persons to reach out to the family of the deceased
- Plan a strategy to respond to requests from parents for information
- Arrange briefings as necessary for staff throughout the crisis period
- Arrange for counselling services to be made available for staff.

The following suicide management checklist should prove helpful

1. Does your school have written policies and procedures?
2. Does the Principal have adequate administrative support and a mental health professional they can consult during the crisis period?
3. Does the school have a Crisis Action Team that it can activate easily and are the team member's roles clearly defined?
4. How and when should staff and students be informed?
5. What form of counselling will be provided for staff and students?
6. Who will staff the counselling centres and where will they be located?
7. For how long will special counselling be provided?
8. Do you have a sample letter prepared for all parents?
9. How will the school respect the family's wishes and privacy?
10. Do you have a school policy on funeral attendance?
11. Who is the spokesperson for the school and what comments will be made to the media?
12. Are there professionals in your school who are competent to assess suicidal students?
13. Do you have good links with community-based services?

**In the long-term the Principal will need to oversee the review and modification of the crisis action plan periodically.**

### The Crisis Action Team

Selection and training of members of the Crisis Action Team should have taken place well in advance of any crisis. Members of the Crisis Action Team should be selected from the school

and the local community, for example, the Principal/Vice-Principal, School Secretary, School Guidance Counsellor, Educational Psychologist, Teacher, Parent, Mental Health Professional(s) (from the Health Board or local Voluntary Organisation). It is essential that the Crisis Action Team can be activated and convened quickly and implements the crisis action plan without delay.

### The Staff

On the morning after the death staff should be briefed. The purpose of this is to

- Enable the staff to become involved in crisis resolution
- Acknowledge their grief and loss
- Prepare them to respond to students.

The following points need to be outlined to staff

- The facts of the death.
- The school's crisis action plan.
- The resources for staff and students.
- How at risk students are identified.
- When and how referrals to agencies outside the school are made.

Information packs for staff are recommended so as to help them in their role in the classroom by giving them more specific information. Useful handouts are:

- Key points to consider when informing the students of the death. This may take the form of a written statement (Appendix 5).
- Common student reactions and recommended staff response to suicide (Appendix 6).
- Review of how survivors feel in the aftermath of suicide (Appendix 7).

Make specific crisis counselling available to staff to discuss their own concerns and feelings, or for questions they may have about their students. Making available an outside mental health consultant considers the privacy of staff and seems to work most effectively.
If the briefing meeting for teachers is held during school hours shortly after a tragedy has been announced, it is very important to make arrangements for the students. Briefing the staff in two shifts leaves teachers free to be available for students. Non-teaching staff e.g. caretaker, nurse, secretarial staff, crossing attendant etc, need to be involved in the briefing and in postvention plans generally

Teachers should be aware that in the immediate aftermath of a tragedy, supporting one another is vital. The support of the staff room becomes even more important than in the normal running of the school.

Hold further staff briefings as necessary (e.g. at the end of the first day), to review the implementation of the crisis action plan. It is important to have a debriefing meeting about a month or six weeks after a tragedy. This is a time when the response of the staff and school is fresh in people's minds and it is a time when plans can be altered. If this opportunity is missed, lessons learned can be lost.

In the longer term, ongoing training of school staff in suicide awareness and prevention should be organised periodically.

## MANAGING KEY RELATIONSHIPS

### The Pupils

In the immediate aftermath of the suicide pupils related to the deceased and close friends will have to be told privately. Their class teacher using a written statement should inform all other pupils and the school routine should be kept as normal as possible.

Ensure that support is available through the School counsellor, educational psychologist, crisis action team and outside agencies such as clergy or the Samaritans as appropriate.

Learning support teachers need to be particularly sensitive to the requirements of children with special needs (e.g., children with learning disabilities) who attend the school. Such children may need particular attention and support. Are they at school? Have they been informed of what has happened? How are they coping?

Identify locations for counselling services for pupils and arrange specific support for vulnerable pupils; for example, close friends and relations of the deceased pupil, pupils with a history of self-harm, or pupils who have been bereaved by suicide in the past. Refer on to mental health professional as appropriate.

In the longer term schools may use their Social, Personal, Health and Educational programme (see Section II) or pastoral care programme to deal with related issues for pupils in a useful way.

Students need to be with people they know and trust when they are experiencing the trauma of the aftermath of a tragedy. They will be more likely to share their feelings and ask questions of familiar adults than strangers. For this reason schools could perhaps use the “expert” to brief the teachers and give them confidence and answer their questions, but have the teachers interface with the students.

Frequently young people will want to confide in each other rather than adults; this should be recognised and acknowledged. Often it is useful to assist a young person in identifying a friend in whom they can confide their feelings. (They don’t have to disclose to or confide in the whole class)

### The Parents and Guardians

In the immediate aftermath of the suicide there should be an agreed strategy on how to deal queries from parents’ and guardians. In addition consideration should be given to preparing a letter to them which gives the following information:

- Brief facts about the death.
- Advice on supporting their child through the crisis.
- An outline of how the school is responding/providing support.

In the long term the parents association needs to be encouraged to participate in the development and monitoring of the school postvention policy. Parents have a valuable role to play in evaluating how they can provide support in the aftermath of tragedy.

### The Family

Agree the nature of support the school can offer the family of the deceased pupil following the suicide. Nominate one or two persons who will make contact with the family to offer sympathy on the school's behalf. This person can also discuss with the family its wishes for the school's involvement and support re funeral etc.

In the long term the nominated person should discuss with the family the returning of their deceased child's belongings from school. The Crisis Action Team may provide the family with a list of local counselling/support services available following bereavement by suicide. The family may be consulted about their wishes re services or other events planned to mark the anniversary.

### The Community

The relevant community agencies should be identified and the school postvention plan should be discussed with them prior to a crisis. The names and phone numbers of contact persons (including after hours) should be readily available.

Community supports may include:

- The family doctor
- School psychologist and/or other professionals who visit the school
- Youth organisations
- Helplines (e.g. Samaritans)
- Gardai
- Clergy
- Local Suicide Bereavement Support Services
- Emergency units
- Crisis/distress centres
- Media
- Local Child Guidance service or Community Care Psychology service
- Local voluntary agencies
- Funeral directors

For the purposes of long term planning the school should encourage youth participation in community activities in order to foster a sense of belonging to the community, enhance their self-esteem and to help them develop life skills such as leadership, problem solving and team building.

### The Media

In the short term agree a procedure for dealing with the media. As the media may approach any member of school staff, it is important to designate one person only (with one backup) as spokesperson. Staff are recommended to consult the joint publication of the Samaritans and the Irish Association of Suicidology, "Media Guidelines on Portrayal of Suicide" for useful guidelines on responsible reporting of suicide.

Prepare a brief written statement expressing the school's grief at the death and explaining the actions being taken to meet the needs of the pupils. In order to respect the family's privacy,

strongly discourage staff and pupils from talking to the media about the death. Provide support for the person dealing with the media.

In the longer term the school's spokesperson should have ongoing contact with members of the media with the aim of educating the media about responsible suicide reporting practices in an effort to lower the negative and potentially contagious effects that sensational publicity about suicide can have on vulnerable youth.

This imitation or "contagion" effect appears to be strongest among adolescents because of their particular developmental stage, which typically includes a heightened need for acceptance, belonging and approval from their peers. In responsible reporting of suicide, media reports should AVOID:

- presenting the story on the front page of the publication or as the lead story of a news broadcast
- presenting simplistic cause-effect explanations for suicide such as "Teen kills himself because he failed a test"
- glorifying suicide or persons who complete suicide
- engaging in a repetitive, ongoing, or excessive reporting of suicide in the news
- presenting the story in a sensational manner by providing details and the use of dramatic photographs related to the suicide
- reporting technical "how-to" descriptions about how the suicide was completed
- presenting suicide as a tool for accomplishing certain ends
- focusing solely on the suicide completer's positive characteristics in a glorifying manner
- mentioning other past suicides as part of the news story or hinting at a suicide epidemic

## MANAGING EVENTS IN THE AFTERMATH OF A SUICIDE

### The Funeral

Decide on the school's policy re attendance of staff and pupils at the funeral as appropriate. Some of the literature recommends that school involvement in the funeral of a student who has died by suicide should be the same as for any student death, whether it is natural, accidental or otherwise, as to respond in a unique way to a death by suicide may further glorify it as a mode of death.

Ensure classes are covered for staff attending the funeral. Students or staff returning to school directly after the funeral may need extra support throughout the day.

### The Inquest

The inquest is a time when memories of the tragedy may revive emotional reactions experienced at the time of a pupil's death. Staff, pupils and family may need personal consideration at this time. The measures for dealing with the media should be reintroduced for the period of the inquest.

### The Anniversary

The anniversary of the pupil's death may revive deep feelings among pupils and staff. Care should be taken if considering a memorial service or similar event at this time to mark the occasion. Consultation should take place with the deceased pupil's family to act in accordance with their wishes.

## CONCLUSION

There is general consensus in the suicide prevention field that the development of school policy and procedures represents a very critical component of comprehensive school-based suicide prevention programmes.

In order to promote a participatory approach, it is important to ensure that there are ample opportunities for staff, students, parents and community members to have input into the development, implementation and evaluation of the policy.

# APPENDIX

## 1 TO 16

# APPENDIX 1

Report of the National Task Force on Suicide 1998 recommendations that are relevant to the formal primary and secondary education sector.

- Teachers at all levels be supported in respect of the psychological and social dimensions of their work, through undergraduate and continued professional education courses.
- Programmes should be initiated aimed at teaching children about positive health issues including coping strategies and basic information about positive mental health at an early stage as a natural part of their health care curriculum.
- Guidance counsellors be available in all schools.
- The psychological services delivered to schools by the department of education and Science be extended so that the needs of all students can be met without undue delay.
- The Department of education and science in conjunction with the Health Promotion Unit of the Department of health and Children introduce a broad based Social and Personal Health Education (SPHE) Programme in our primary and secondary schools to be implemented throughout the school cycle.
- Social and Personal Health Education (SPHE) include modules on depression awareness and anger control skills.
- Greater collaboration to take place in schools between staff, pupils and parents' associations and the local Health Boards to promote positive health.
- Steps to be taken to make the health services, including the mental health services, more accessible to the public, particularly the young, who may at present perceive them as not being available to address their needs at times of crisis.
- Youth mental health needs to be recognised at an early stage and interpreted correctly.
- Children and young people at a time of crisis to have access to appropriate support services and a comprehensive range of psychological and counselling services should be available.
- All children be taught to swim as part of their general education with a view to enhancing health and preventing accidental drowning as well as suicide.
- All individuals who engage in acts of parasuicide should be encouraged to seek professional help, as soon as possible after the event, and where necessary transfer arranged to the accident and emergency unit of the local general hospital.
- Relevant professionals be made aware of what are the appropriate steps for distraught relatives to take should they feel they cannot cope, bearing in mind that the best solution is often to find the resources within one's family and social network.

# APPENDIX 2

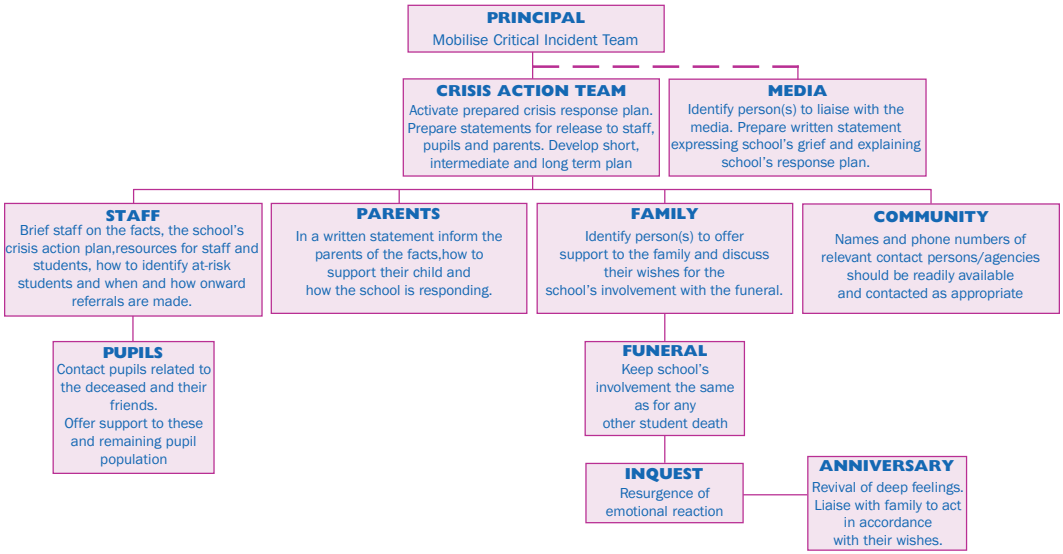
A manual published in 1998 by the Ministry for Children and Families, British Columbia (*Before the fact interventions*) [8] outlines a number of characteristics that schools can aspire to with a view to positively influencing pupil health.

Ten characteristics of healthy and effective schools

1. Shared school goals and vision
2. Continuous academic and social growth
3. Extensive communications with opportunities for input
4. Mutual respect
5. High level of trust
6. Caring and acceptance
7. Clearly defined and consistently applied discipline
8. Play and humour
9. Strong sense of ritual and tradition
10. Pleasant and stimulating environment

# APPENDIX 3

## CRISIS ACTION POSTVENTION FLOWCHART



# APPENDIX 4

## Suicide Management Checklist

1. Does your school have written policies and procedures?
2. Does the Principal have adequate administrative support and a mental health professional they can consult during the crisis period?
3. Does the school have a Crisis Action Team that it can activate easily and are the team member's roles clearly defined?
4. How and when should staff and students be informed?
5. What form of counselling will be provided for staff and students?
6. Who will staff the counselling centres and where will they be located?
7. For how long will special counselling be provided?
8. Do you have a sample letter prepared for all parents?
9. How will the school respect the family's wishes and privacy?
10. Do you have a school policy on funeral attendance?
11. Who is the spokesperson for the school and what comments will be made to the media?
12. Are there professionals in your school who are competent to assess suicidal students?
13. Do you have good links with community-based services?

# APPENDIX 5

## Key points to consider when informing students of the death

1. Express sadness at the news of the death.
2. Send condolences to family and friends.
3. Give information on what counselling/supports will be available for students.
4. Give information available about the funeral arrangements.

# APPENDIX 6

## Common Student Reactions and Recommended Staff Response

While the emotional responses of students do not occur in a uniform manner, they are somewhat predictable in nature. The following summary of reactions and responses is adapted from Lamb and Dunne-Maxim's "Postvention in Schools, Policy and Process" in *Suicide and Its Aftermath*, Edward J. Dunne, Karen Dunne-Maxim, and John L. McIntosh, eds:

| STUDENT REACTION | STAFF RESPONSE |
|---|---|
| **Shock and Denial**<br>Initially, students may appear Remarkably unresponsive to the news of a suicide. They find it difficult to accept the reality of the death. "You have to be kidding!" | Staff need to assume a stance of anticipatory waiting, acknowledging the shock and demonstrating a willingness to talk when the students feel ready. |
| **Anger and Protection**<br>Students will look for someone to blame. Anger may be directed at adults in the deceased's life, including school staff. "Why did they let it happen?" | Staff members can listen to student feelings. Explaining that blame is a normal reaction to an event that can't be explained is sometimes helpful. |
| **Guilt**<br>Typically students who knew the deceased may move from blaming others to blaming themselves. "If only I had talked to him more." | Staff can help by reminding students about the limits of personal responsibility. |
| **Anger at the deceased**<br>This is not uncommon, even among those who were not really close to the deceased. "How could he be so stupid to do such a thing?" | Allowing some expression of anger is ameliorative. Staff can point out that feeling angry that someone has chosen to leave us is normal. A simple acknowledge – ment of this feeling may lessen its intensity. |

| STUDENT REACTION | STAFF RESPONSE |
| --- | --- |
| **Anxiety**<br>Students may begin worrying about themselves. "If he could kill himself because he was upset, maybe I (or my friends) could, too." | Discussion should be guided toward helping students differentiate between themselves and the deceased.<br>Problem-solving options and alternatives to suicide can also be introduced. |
| **Loneliness**<br>For those close to the deceased, returning to valued interactions with friends may seem impossible. "Being with my friends seems so empty without him around." | It is important that people not feel alone with their grief. Staff can foster sharing by encouraging students to work together in Finding positive ways to help each other move on with their lives. |
| **Hope and Relief**<br>Making it through the normal feelings depends upon an acceptance of the reality of the death and a belief that the pain and hurt will eventually subside. "I know I'll feel better in time." | Staff should recognise both the importance of mourning and the fact that the process takes time. Remaining open to the expression of feelings by students is helpful. |

# APPENDIX 7

The following extract is taken from, Managing Sudden Traumatic Loss In The Schools. New Jersey Adolescent Suicide Prevention Project. (1997) by M. Underwood & K. Dunne-Maxim.

## THE AFTERMATH OF SUICIDE

### Denial

Sometimes people need to deny the fact that the death was a suicide. They claim the death was an accident or caused by foul play. This can happen even when there have been previous suicide attempts, a history of depression, or verbal statements about suicide. Denial is a fragile defence mechanism and it is often non-productive to engage in a power struggle with those who need to cling to this belief. In time, these survivors usually accept the truth.

### Searching for the why's

It is common for people to search relentlessly for an explanation of the death. The research into the causes of youth suicide is only just beginning. Currently, researchers have conceptualised suicide potential in terms of an interaction of biochemical, psychological, and social factors, and a major question continues to be at what level and to what degree each of these factors combine to enhance someone's risk for suicide. Recent psychological autopsy studies have indicated that the majority of young people who complete suicides are in fact suffering from biologically-based mental illnesses. The most common error people make is to attribute a single reason to a particular suicide, forgetting that each suicide is a complex event. Our search for a single reason may be a way to explain away what is so psychologically unsettling, e.g., the fact that a person would chose to end his/her own life.

### Distortion of the truth

Rumours are common as everyone seeks to come to grips with this shocking, unacceptable loss. In many situations, we have heard details about a particular death from the family, school, and sources within the community. When we piece the information together, it becomes clear that untrue information is circulated as facts. It is important to be aware of this, so that your responses can be planned accordingly.

### Guilt

Most survivors experience exaggerated feelings of responsibility for the death. In one instance after a young man's death, our team heard a janitor say, "If only I had smiled at him that day, the way I did on other days, he would still be alive." Almost everyone has an "if only". It is by talking to others and hearing their "if only", that one can recognise that it is often grandiose to think that if only you had behaved differently, the child would be alive. The reality is that one person cannot assume total responsible for the act of another. More accurately, "if only" you had known clearly what the victim's intentions were, you would have tried to prevent the death. The victim, because of his or her own inner turmoil was not able to communicate this to you. Even warning signs are suggestive, not definitive, and in some cases even trained mental health professionals have difficulty assessing suicidal risk.

### Anger

Anger is a common and natural reaction to the event. Adults usually express less anger at the victim than young people do because they understand that the mental condition of the victim may have prevented him from communicating his distress directly. Young people may rely more on emotions than logic and react to suicide in a more personal level. Expression of anger by young people may take the form of "how could he/she do this to us?" When anger is present, there is no need to suppress or fight it. One needs to accept it, and verbalise or release it in appropriate ways.

### Scapegoating

In some cases anger and misunderstanding may cause survivors to "scapegoat" others by blaming them for the suicide. Again, in every suicide it is inaccurate to reduce the blame to a single explanation. Blaming someone else, an institution, or the community at-large for the death is too simplistic and ignores both the complexity and the often irrational quality of suicidal thinking. Scapegoating is simply a way to channel anger inappropriately.

# APPENDIX 8

| Contact: | Name | Phone No. |
|---|---|---|
| Ambulance, Fire Brigade, Gardai | Emergency services | 999 |
| Dept. Education Psychology Dept. | Educational Psychologist for the area. | |
| Chair. Board of Management | | |
| School Principal | | |
| Home school liaison officer | | |
| School Guidance counsellor / School nurse | | |
| School media spokesperson | | |
| Health Boards School Support staff | | |
| Health Board Psychology services | | |
| Local General Practitioners | | |
| Child and Adolescent Psychiatric services | | |
| Adult Psychiatric Services | | |
| Accident and Emergency Dept local hospital | | |
| Addiction services | | |
| Youth Counselling services | | |
| Bereavement support agencies | | |
| Additional Useful Numbers | | |

# APPENDIX 9

## USEFUL TELEPHONE NUMBERS

| AGENCY | TELEPHONE NUMBER |
|---|---|
| The Samaritans | 1850 60 90 90 (24 hrs) |
| Childline | 1800 666 666 (24 hrs) |
| Parentline | 01 873 3500 |
| Alcoholics Annonymous | 01 453 8998 |
| Al anon - Alateen | 01 873 2699 |
| Narcotics Annonymous | 01 830 0944 |
| Victim Support | 1800 661 771 |
| National Suicide Bereavement Support Network | 024 95561 |
| Gay Switchboard | 01 872 1055 |
| Anti Bullying Research and Resource Unit (TCD) | 01 608 2573 |
| Bodywhys (Eating distress) | 01 2835126 |
| Barnardo's | 01 4530355 |
| Garda Confidential Line | 1800 666 111 |
| Rape Crisis Centre | 1800 323232 |
| Family Law Information | 1850 391 391 |
| Cura (unplanned Pregnancy ) | 01 679 8989 |
| National Pregnancy Helpline | 1850 495 051 |
| Aware (Depression) | 01 676 6166 |
| Schizophrenia Ireland | 1890 621 631 |

# APPENDIX 10

## THE MYTHS OF SUICIDE

The following are common myths or false beliefs about suicide. They are misleading and can prevent people from making the correct choices in times of crisis and thereby prevent people from getting appropriate help. They must be challenged and the assumptions and prejudices underlying them help to recognise those who are at risk of suicide.

**1. Young people who talk about suicide never attempt or complete suicide.**
**Fact**
Research shows that about eighty percent of those who take their own lives will have talked about it to some significant other, parent, friend, counselor or doctor in the months and weeks before the event. Talking about suicide can be a plea for help and must be taken seriously.

**2. A promise to keep a note unopened and unread should always be kept.**
**Fact**
When the potential for harm, or actual harm, is disclosed then **confidentiality** cannot be maintained.

A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note is a late sign in the progression towards suicide.

**3. If a person attempts suicide and survives, they will never make a further attempt.**
**Fact**
A suicide attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each further suicide attempt. Ten percent make a further attempt within one year and in that time one percent go on to complete suicide. A previous suicide attempt is a very high risk factor for subsequent suicide

**4. People who threaten suicide are just seeking attention.**
**Fact**
All suicide attempts must be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-gaining device.

**5. Attempted or completed suicides happen without warning.**
**Fact**
Those close to a person who has completed suicide often say that the intention was hidden from them. It is more likely that the intention was not recognised. These warning signs include:

**6. Once a person is intent on suicide, there is no way of stopping them.**
**Fact**
Suicides can be prevented. People can be helped. Suicidal crises can be relatively short-lived. Suicide is a permanent solution to what is usually a temporary problem. Immediate practical

help, such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or complete suicide. Such immediate help is valuable at a time of crisis, but appropriate counselling will then be required. The majority of people who take their own lives are ambivalent about their proposed course until the very end.

7. Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.
Fact
Talking about suicide does not instill suicidal thoughts. It is necessary for people who feel suicidal to express their feelings so as to get help to manage them. Fears that are shared are more likely to diminish. The first step in encouraging a suicidal person to live comes from talking about feelings. This step can be the simple inquiry about whether or not the person has thoughts of ending their life. However, talking about suicide should be carefully managed.

8. Suicide is painless.
Fact
Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of pain.

9. Depression and self-destructive behaviour are rare in young people.
Fact
Both forms of behaviour are common in adolescents. Depression may manifest itself in ways, which are different from its manifestation in adults, but it is prevalent in children and adolescents. Self-destructive behaviour is most likely to be shown for the first time in adolescence.

10. All suicidal young people are depressed.
Fact
While depression is a contributing factor in most suicides, it need not be present for suicide to be attempted or completed. Suicide rates are high in other psychiatric illnesses such as schizophrenia anxiety states and anorexia nervosa.

11. Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.
Fact
The opposite may be true. In the three months following an attempt, a young person is at most risk of completing suicide. The apparent lifting of the problems could mean the person has made a firm decision to suicide and feels better because of this.

12. Once a young person is suicidal, they will be suicidal forever.
Fact
Most young people who are considering suicide will only be that way for a limited period of their lives. Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns.

13. The only effective intervention for suicide comes from professional psychotherapists with experience in this area.

Fact

All people who interact with suicidal adolescents can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

14. Some people are always suicidal.

Fact

Nobody is suicidal at all times. The risk of suicide for any individual varies across time, as circumstance change. This is why it is important for regular assessments of the level of risk in individuals who are 'at risk'.

15. Every death is preventable.

Fact

No matter how well-intentioned, alert and diligent people's efforts may be, there is no way of preventing all suicides from occurring.

# APPENDIX 11

## RESOURCES FOR SCHOOLS (IRISH)

1. ASTI (1997) **Guidelines for schools on how to respond to the sudden unexpected death of a student**

2. INTO/ Ulster Teachers Union (2000) **When tragedy strikes – Guidelines for effective critical incident management in schools**

3. Irish Association of Pastoral Care in Education (2000) **Living with change and loss**

4. Irish Association of Pastoral Care in Education (2001) **Echoes of suicide:** Dublin, Veritas.

5. Irish Association of Suicidology/ National Suicide Review Group (2000) **Proceedings of the first national conference on suicide prevention in schools**

6. Monaghan, L. (1999) **Suicide bereavement and loss: perspectives and responses:** Dublin, iapce.

7. Mid-Western Health Board (2001) **A student dies – A school responds**

8. North-Western Health Board **In the event of tragedy – a response**

9. Power, R and Moore, N. (1999) **The evaluation of a suicide prevention/mental health promotion service to a secondary school.** (Unpublished Report from the Kildare Child and Adolescent Services).

10. Southern Health Board **In the event of tragedy – a response**

11. Northern Ireland Department of Education (1996) **Suicide among young people: managing the issue in schools:** Belfast

12. Mental Health Ireland (2001) **Mental Health Matters: A Mental Health Resource Pack**

13. Educational Psychological Service : Western Education Library Board Northern Ireland **Grief matters managing behaviour and trauma in schools – a support pack**

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6. Irish Association of Suicidology (1997) **Suicide - Human Tragedy: Global Responsibility** (Proceedings of the second annual conference)

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8. Irish Association of Suicidology (1999) **Living with loss** (Proceedings of the fourth annual conference)

9. Irish Association of Suicidology (2000) **Youth Suicide** (Proceedings of the fifth annual conference)

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18. Kelleher, M.J., Keohane, B., Daly, C., Keeley, H.S., Corcoran, P, Chambers, D. & Williamson, E. (1999). **Individual characteristics and long term outcome for deliberate self-poisoners.** Journal of the Irish College of Physicians and Surgeons, 28,1, 5-8.

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5. **Before the Fact- A manual of best practice in youth suicide prevention** Ministry for Children and Families British Columbia

6. Callahan J. (1996) **Negative effects of a school suicide postvention programme – a case example** Crisis 17/3

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9. Grossman et al (1995) **Strategies for school-based response to loss: proactive training and postvention consultation** Crisis 16/1

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27. Williams, R (1994) **Suicide prevention: the challenge confronted, a manual of guidance for the purchasers and providers of mental health care:** London, HMSO.

28. Yule W. and Gold A. (1993) **Wise before the event: coping with crises in schools.** Calouste Gulbenkian Foundation: London

29. Ramefedi G (1999) **Sexual Orientation and youth suicide.** Journal of the American Medical Association 282

# APPENDIX 12

## WEBSITES

| ADDRESS | DESCRIPTION/ GOOD FOR |
|---|---|
| http://www.ias.ie | Irish Association of Suicidology |
| http://www.suicidology.org | American Association of Suicidology |
| http://www.samaritans.org.uk | The Samaritans UK and Ireland |
| http://www.wfmh.com | World Federation of Mental Health (good links) |
| http://www.suicide-parasuicide.rumos.com | Good site, up to date. |
| http://www.who.int/mental.health/suicide/resources.html | WHO site, has downloadable guidelines from 2000 for schools. |
| http://www.afsp.org | Association for Suicide Prevention |
| http://www.suicideinfo.cal | Canadian site, downloadable information sheets |
| http://www.mensana.org | Mental Health Association of Ireland (very accessible information on mental health issues). |
| http://www.survivingsuicide.net | Website for people bereaved by suicide in the UK and Ireland |
| http://homepage.eircom.net/~nsbsn | Irish website for people bereaved by suicide, lists support groups |
| http://www.brcic.org | American website for center that provides support to people bereaved by suicide. |
| www.virtualcity.com/youthsuicide | Website that provides overview of research regarding sexual orientation and suicidality |
| http://www.curriculum.edu.au/mindmatters | |

# APPENDIX 13

## IRISH ASSOCIATION OF SUICIDOLOGY

## CONSENSUS STATEMENT ON SUICIDE PREVENTION IN SCHOOLS

### Proposals Specific for the Education Sector

1. Central government (in the Republic of Ireland the Department of Education and Science and the Department of Health and Children and in the North of Ireland the Department of Health, Social Services and Public Safety and the Department of Education) should as a matter of urgency through joint working, put in place a clear and visible strategy and support to enable schools to respond to the mental health challenge of young people at risk of suicide and with the aftermath of suicide.

2. Schools in Ireland must develop specific in-house expertise for responding to the needs of children and young people at risk of self-harm.

3. Suicide prevention must be addressed in the context of a broad generic programme of social, personal and health education.

4. Teachers play a pivotal role in suicide prevention in schools. To enable them to fulfil this role they must be provided with the necessary support and training. The limitations of the role of the teachers also needs to be recognised and clarified, through school policy and Department of Education policy.

5. Schools must be resourced by adequate numbers of counsellors and psychologists.

6. Undergraduate teacher training must be provided in suicide awareness and in dealing with suicide and other trauma postvention.

### PROPOSALS FOR THE HEALTH SECTOR

1. There is a need for greater understanding of the psychodynamics of suicide in Irish schools.

2. There is a need for focus on the underlying mental health problems and social difficulties among youth and to provide appropriate support and treatment services.

3. Comprehensive programmes of intervention are essential.

4. Suicide prevention in schools and colleges requires locally accessible and responsive mental health services.

# APPENDIX 14

## ORAL CONSULTATIONS

Association of Secondary Teachers (A.S.T.I.)
Winetavern Street, Dublin 8

Aware
72 Lower Leeson Street, Dublin 2

Institute of Guidance Counsellors,
17 Herbert Street, Dublin 9

Irish Association for Pastoral Care in Education (I.A.P.C.E.)
Marino Institute of Education,
Griffith Avenue, Dublin 9

Irish National Teacher's Union Organisation (I.N.T.O.)
35 Parnell Square, Dublin 1

National Education Psychology Service (N.E.P.S.)
Marlborough Street, Dublin 1

National Parents Council Post Primary,
Marino Institute of Education, Griffith Avenue, Dublin 9

National Youth Council of Ireland
3 Montague Street, Dublin 1

The Samaritans
112 Marlborough Street, Dublin

Social Personal & Health Educaion (S.P.H.E.)
Support Services Post Primary,
Marino Institute of Education, Griffith Avenue,
Dublin 9

Teachers Union of Ireland (T.U.I)
73 Orwell Road, Dublin 6

Ulster Teacher's Union
94 Malone Road, Belfast

Health Promotion Department
Eastern Health Board,
Dr. Steevens' Hospital, Dublin 8

Health Promotion Department
Midland Health Board,
Arden Road, Tullamore, Co. Offaly

Health Promotion Department
Mid Western Health Board,
31/33 Catherine Street, Co. Limerick

Health Promotion Department
North Eastern Health Board,
Kells, Co. Meath

Health Promotion Department
North Western Health Board,
Manorhamilton, Co. Leitrim

Health Promotion Department
South Eastern Health Board,
Lacken, Dublin Road, Co. Kilkenny

Health Promotion Department
Southern Health Board
Wilton Road, Co. Cork

Health Promotion Department
Western Health Board,
Merlin Park Regional Hospital, Co. Galway

# APPENDIX 15

## WRITTEN CONSULTATION ON MANAGING SUICIDE PREVENTION IN IRISH SCHOOLS: BEST PRACTICE GUIDELINE

### INTRODUCTION

During December, 2001, 324 individuals who had attended either the Joint Irish Association of Suicidology (IAS) and National Suicide Review Group (NSRG) Conference on Suicide Prevention in Schools held in Galway in December, 2000, or the 'To be or not to be? Questions of life and death' Conference jointly organised by Aware and the Foyle Health and Social Services Trust and held in Derry in November, 2001, were sent a copy of the 'Managing Suicide Prevention in Irish Schools: Best Practice Guidelines' document and a questionnaire which asked for feedback relating to the content of the document.

The majority of these individuals were secondary school teachers. Seventy (22%) responded. The response rate may be seen as disappointing. However, They first had to read and consider the contents of the thirty-page document. Given the short time scale that was allowed for the return of questionnaires and the time commitments of secondary school teachers are very grateful to those who did respond.

### RESULTS

The first section of the questionnaire consisted of six statements, one or two relating to each of the four sections of the documents. The statements sought to assess the impact or benefit gained from reading the particular section. Respondents were asked to indicate to what extent they agreed with the statement on a five-point Likert scale ranging from 'Strongly agree' to 'Strongly disagree'. The statements were as follows:

*Section I: Youth suicidal behaviour in Ireland: a background*

1. This section gives a clear description of trends in youth suicidal behaviour in Ireland.
2. This section has helped me to better understand the nature of risk and protective factors in youth suicidal behaviour.

*Section II: Prevention of suicide in the school setting*

3. Having read this section, I have a greater understanding of the range of preventive activities that can be used to address the issue of suicide in the school setting.

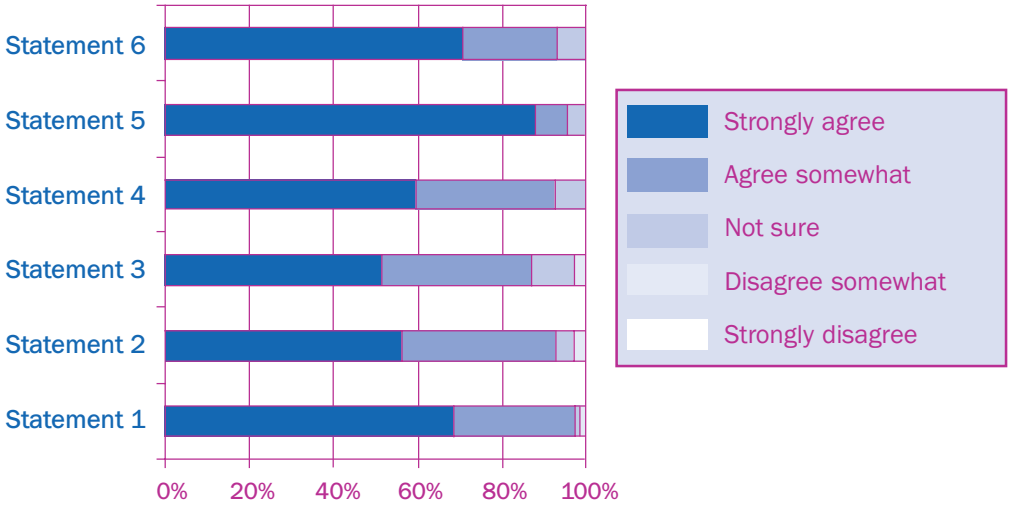
*Section III: Intervention in the school setting*

4. Having read this section, I have a greater understanding of the range of intervention strategies that can be used to address the issue of suicide in the school setting.

*Section IV: Postvention protocols in the school setting*

5. It would be valuable to have a postvention plan in place in the school setting prior to a death by suicide.
6. The model of postvention outlined in this document would be useful/helpful in my school(s).

*The Figure below summarises the responses in relation to these statements.*




Overall, the responses were very positive and supportive. About 90% of respondents agreed (either strongly or somewhat) with the statements.

Ninety-seven per cent agreed (69% strongly) that the first section gave a clear description of trends in youth suicidal behaviour in Ireland. Ninety-two per cent agreed (56% strongly) that this section helped them to better understand the nature of risk and protective factors in youth suicidal behaviour.

Eighty-seven per cent agreed (51% strongly) that the section on prevention of suicide in the school setting gave them a greater understanding of the range of preventive activities that can be used to address the issue.

Ninety-three per cent agreed (59% strongly) that the section on intervention in the school setting gave them a greater understanding of the range of intervention strategies that can be used to address the issue.

Ninety-six per cent agreed (88% strongly) that it would be valuable to have a postvention plan in place in the school setting prior to a death by suicide. Ninety-three per cent agreed (71% strongly) that the model of postvention outlined in the document would be useful/helpful in their school(s).

In the second section of the questionnaire, respondents were asked to rate each of the four sections of the document (out of 10) with respect to its content, clarity, relevance, practicality and comprehensiveness. The overall results were again very positive. For each section of the document, the Table below gives the percentage of respondents who gave a rating between 8 and 10 in terms of the section's content, clarity, relevance, practicality and comprehensiveness.

| | Content | Clarity | Relevance | Practicality | Comprehensiveness |
|---|---|---|---|---|---|
| *Section I* | 82% | 81% | 90% | 89% | 76% |
| *Section II* | 81% | 79% | 82% | 63% | 67% |
| *Section III* | 83% | 84% | 85% | 66% | 76% |
| *Section IV* | 85% | 88% | 88% | 66% | 87% |

Generally speaking, in excess of 80% of respondents gave a rating of at least 8 to each section with respect to the five dimensions. This proportion dropped to about two-thirds in relation to the practicality of the sections on prevention, intervention and postvention.

# APPENDIX 16

QUESTIONNAIRE

Managing Suicide Prevention in Irish Schools:
BEST PRACTICE GUIDELINES

Section I:

| Youth Suicidal Behaviour in Ireland: A Background | Strongly Agree | Somewhat Agree | Not Sure | Somwhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 1. This section gives a clear/thorough description of trends in youth suicidal behaviour in Ireland | | | | | |
| 2. This section has helped me to better understand the nature of risk and protective factors in youth suicidal behaviour | | | | | |

Section II:

| Prevention of Suicide in the School Setting | Strongly Agree | Somewhat Agree | Not Sure | Somwhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 3.Having read this section I have a greater understanding of the range of preventive activities that can be used to address the issue of suicide in the school setting? | | | | | |

Section III:

| Intervention in the School Setting | Strongly Agree | Somewhat Agree | Not Sure | Somwhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 4. Having read this section I have a greater understanding of the range of intervention strategies that can be used to address the issue of suicide in the school setting? | | | | | |

Section IV:

| Postvention Protocols in the School Setting | Strongly Agree | Somewhat Agree | Not Sure | Somwhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 5. It would be valuable to have a postvention plan in place in the school setting prior to a death by suicide | | | | | |
| 6. The model of postvention outlined would be useful/helpful in my school | | | | | |

7. What additional information if any, should be included in this document?

8. What assistance, support or resources do schools need in order to implement these guidelines in relation to suicide prevention and intervention?

9. Is the information provided in an understandable format i.e. easy to read and well laid out?

   Yes / No (please circle)

10. Are there any additional comments you consider relevant?

11. Name a resource (book, video etc.) which you feel would be useful for other teachers about any of the issues mentioned in this document (i.e. mental health issues, mental health promotion, dealing with crisis situations)

Thank you for taking the time to review the document and complete this questionnaire. Please return the completed questionnaire to Irish Association of Suicidology, St. Mary's Hospital, Co. Mayo, together with any further comments or suggestions you may have.

# VOLUNTARY ORGANISATIONS

| | | |
|---|---|---|
| AWARE | AWARE is a voluntary organisation formed in 1985 by a group of interested patients, relatives and mental health professionals. To provide support group meetings for sufferers of depression and manic depression and their families. | AWARE<br>72 Lower Leeson St.,<br>Dublin 2<br>Tel: 01 8308449<br>Helpline: 01 676616 |
| ALCOHOLICS ANONYMOUS | AA is a self-help programme for people who may have a problem with alcohol. Group meetings are held in most towns throughout the country. | Tel: 028 90 774879 N.I.<br>Tel: (01) 4538998 |
| BODYWHYS | Bodywhys is a charity which offers help, support, understanding and information to people with anorexia or bulimia nervosa to families and friends and to professionals involved in the treatment of eating disorders. | Bodywhys Central Office,<br>PO Box 105 Blackrock<br>Co Dublin.<br>Tel: (01) 2834963 |
| CHILD BEREAVEMENT (NI) | | Tel: 028 90 403000 |
| CRUSE BEREAVEMENT CARE (NI) | Cruse exists to enable anyone bereaved by death to understand their grief, cope with their loss and emerge with a sense of hope for their future. | (Regional Headquarters)<br>Tel: 028 90 792419 |
| FOYLE SEARCH & RESCUE | Foyle Search & Rescues main aim is the preservation of life in and around the river Foyle. It is made up of volunteers that patrol the banks of the river | Tel: 01 504 313800<br>e-mail foylesearch@<br>foylesearch.demon.co.uk |
| GAMBLERS ANONYMOUS | Gamblers Anonymous is a self-help for people who may have a problem with gambling. | Tel: 028 71 351329 N.I.<br>Tel: 028 90 249185 N.I.<br>Tel: (01) 8721133 |
| GROW | GROW aims to help the individual grow towards personal maturity by use of their own personal resources, through mutual help groups in a caring and sharing community. The programme is based on providing a supportive environment for its group members. | GROW<br>National Office,<br>Grow Centre,<br>11 Liberty Street, Cork<br>Tel: 021 277520 |

| | | |
|---|---|---|
| LEGAL AID BOARD | The Legal Aid Board provides legal aid and advice in civil cases to persons who satisfy the requirements of the Civil Legal Aid Act. 1995. The Board makes the services of Solicitors and if necessary Barristers available to people of moderate means at little cost. The service includes anything from writing a solicitors letter on your behalf to representing you in court. In practice the Board deals mainly with family law. | Legal Aid Department<br>Tel: 028 90 246441 N.I.<br>Tel: (01) 6615811 |
| MENTAL HEALTH ASSOCIATION OF IRELAND | The Mental Health Association of Ireland (MHAI) is a national voluntary organisation with over 90 local association and branches working throughout the country. Its aim is twofold - to help those who are mentally ill and to promote positive mental health. | Tel: 01 2841166<br>www.mensana.org<br>e-mail mhai@iol.ie |
| NAR-ANON | Nar-Anon is a self-help group for relatives and friends of people who may have a problem with drugs. | Tel: (01) 8748431 |
| NARCOTICS ANONYMOUS | NA is a self-help group for people who feel they may have a problem with drugs. | Tel: (01) 2084107 |
| NATIONAL YOUTH FEDERATION | The National Youth Federation (NYF) is Ireland's largest youthwork organisation. The NYF has published research on young people and suicide, produced guidelines for youth workers on prevention and postvention work and provides workshops on the use of the guidelines. | Tel: 01 8729933<br>e-mail fbissett@nyf.ie |
| NORTHERN IRELAND MENTAL HEALTH ASSOCIATION | | Tel: 028 90 328474 |

| | | |
|---|---|---|
| OVEREATERS ANONYMOUS | The only requirement for overeaters anonymous membership is a desire to stop eating compulsively. | Tel: (01) 4515138 |
| PRISM – BEREAVED AND SEPARATED PARENTS. | A programme specially designed for bereaved and separated parents. It helps them to become attuned to their own and their child's grief process and to learn single parenting skills so they can recreate family life again. | |
| QANDA, THE ASSOCIATION FOR PHOBIAS IN IRELAND | OANDA was set in 1974 as the National Organisation for sufferers of Agoraphobia. | QANDA, 140 St. Lawrence's Rd., Clontarf, Dublin 3. Tel: 01 8338252/3 |
| RAINBOW PROGRAMME | Rainbows is a support group programme for children and young adults who have suffered a significant loss through death or separation or any painful transition. | Tel: 042 71235 |
| SAMARITANS | The Samaritans vision is that fewer people will take their own lives. Samaritans befriending is available at any hour of the day or night for everyone passing through personal crisis and at risk of dying by suicide. Samaritans provide society with a better understanding of suicide, suicidal behaviour and the value of expressing feelings that may lead to suicide. | Linkline Tel: 0345 909090 N.I.<br><br>Tel: 1 850 60 90 90<br><br>www.samaritans.org |
| SCHIZOPHRENIA IRELAND | Schizophrenia Ireland is the national organisation dedicated to advocating the rights and needs of those affected by schizophrenia and related illnesses, and to promoting and providing best quality services for the people it serves | Schizophrenia Ireland 38 Blessington Street, Dublin 7. Tel: (01) 860 1620<br><br>Helpline: 1890 621 631<br>http://www.iol.ie/lucia<br>Email: schizi@iol.ie |

# SUICIDE BEREAVEMENT SUPPORT GROUPS

| | |
|---|---|
| CARLOW. | **Carlow Suicide Bereavement Support Group**<br>Dublin Rd., **Co. Carlow.** Tel: 0502 51277 |
| CAVAN. | **Cavan Family Support Group**<br>Family Resource Centre, Main St., **Co. Cavan.** 049 71363 |
| CORK. | **FRIENDS OF THE SUICIDE BEREAVED**<br>PO Box 162, **Co. Cork.** Tel: 021 249318<br>**IRISH FRIENDS OF THE SUICIDE BEREAVED**<br>The Planning Office, St. Finbarr's Hospital, **Co. Cork.** Tel: 02136722<br>**YOUGHAL SUICIDE BEREAVEMENT SUPPORT GROUP**<br>League of the Cross Hall, Grattan Street, Youghal, **Co Cork** ,<br>Tel: 024 95561. e-mail nsbsn@eircom.ie |
| DUBLIN. | **THE BEREAVEMENT COUNSELLING SERVICE**<br>Dublin St., Baldoyle, **Co. Dublin.** Tel: 01 8391766<br>**HERBER C/O IRISH HOSPICE FOUNDATION**<br>64 Wellington Rd., **Dublin 4,** Tel: 01 6603111<br>**NORTHSIDE COUNSELLING CENTRE**<br>Bunratty Drive, Bonnybrook, **Dublin** 17. Tel: 01 8484789<br>**SUICIDE BEREAVEMENT GROUP**<br>Institute of Psychosocial Medicine, 2 Eden Park, Dun Laoghaire,<br>**Co. Dublin** (beside Sandycove Dart Station) Tel: 01 8370433<br>**SUICIDE BEREAVEMENT SUPPORT GROUP**<br>Spirtan House. 213 Nth. Circular Road, **Dublin 7**,<br>Tel: 01 455382 Tel: 01 8640914<br>**TALLAGH SUICIDE BEREAVEMENT SUPPORT GROUP**<br>Tallagh Hospital, **Dublin.** Tel: 01 8370433<br>**DOCHAS,**<br>The Oratory, Blanchardstown Centre, (Yellow Entrance). Tel: 018200915 |
| GALWAY. | **TUAM DAY HOSPITAL**<br>Hermitage Court, Dublin Rd. **Tuam Co. Galway**<br>Ms. Marie Mulryan Ms. Carmel O'Dea Tel: 094 - 24693<br>**DEPARTMENT OF PSYCHIATRY**<br>University College Hospital, **Galway**<br>Ms. Cathy Eastwood Mr. John Marley Tel: 091 544458 |
| KILKENNY. | **BEREAVEMENT SUPPORT GROUP**<br>27, Riverview, **Kilkenny.** Mr. Padraig Morrow Tel: 056 626421 |
| KERRY. | **KENMARE BEREAVEMENT SUPPORT GROUP**<br>C/O The Presbytery, Kenmare, **Co. Kerry.**<br>Tel: 064 41222 / 086 814 5856 |
| KILDARE. | **KILDARE SUICIDE BEREAVEMENT SUPPORT GROUP**<br>Parish Centre, Church of Irish Martyrs, Ballycain, Naas, **Co. Kildare.**<br>Tel: 045 895629 |
| LAOISE. | **COMMUNITY MENTAL HEALTH CENTRE,**<br>Bridge St., Portlaoise Co-ordinator - Ann Cass |
| LONGFORD. | **COMMUNITY MENTAL HEALTH CENTRE**<br>Dublin Rd., Co-ordinator - Ann Howard. |

| | |
|---|---|
| MAYO. | SOLACE, SUICIDE BEREAVEMENT SUPPORT GROUP<br>The Family Centre, Castlebar, **Co. Mayo.**<br>Tel: 094 25900 e-mail mtfahy@hotmail.com |
| OFFALY | COMMUNITY MENTAL HEALTH CENTRE<br>Wilmer Rd. Birr, Co. Offaly. Co-ordinator - Claire Hernon<br>CLOGHAN HOUSE<br>Arden Rd., Tullamore. Co-ordinator - Sr. Gerard McCarthy |
| ROSCOMMON | BOYLE SUICIDE BEREAVEMENT SUPPORT GROUP<br>Family Centre, Boyle, **Co. Roscommon.**<br>Tel: 079 63000<br>FAMILY LIFE CENTRE<br>Vita House, Abbey St., Roscommon. Sr. Mary Lee Tel: 0903 25898 |
| TYRONE | PATHS, POSTGRADUATE CENTRE<br>Tyrone County Hospital, Omagh, **Co. Tyrone.**<br>Tel: (08) 01 662 245 211 |
| WESTMEATH | MULLINGAR SUICIDE BEREAVEMENT SUPPORT GROUP<br>Bethany, Bishopsgate St., Mullingar, **Co Westmeath.**<br>Tel: 044 42746<br>COMMUNITY MENTAL HEALTH CENTRE<br>Grace Rd., Mullingar. Co-ordinator - Bernadette Burke<br>HEALTH CENTRE,<br>District Hospital, **Athlone.** Co-ordinator - Bernadette Sheriff. |
| WEXFORD | H.O.P.E. SUICIDE BEREAVEMENT SUPPORT GROUP<br>Community Health Centre, Summerhill **Co. Wexford.**<br>Tel: 053 23899 |
| WATERFORD | CAIRDEAS,<br>Tel: 1 850 201249 |
| WICKLOW | SUICIDE BEREAVEMENT SUPPORT<br>Holy Redeemer Parish Centre, Bray, **Co. Wicklow.**<br>Sr. Sheila O'Kelly Tel: 01 2868413 |

# STATISTICS

# CURRENT STATISTICAL DATA

## Table 1a. Suicide, undetermined death, death by external causes, death by all causes, 1976-1999 (Persons)

| Year | Suicide | | Undetermined death | | Death by external causes | | Death by all causes | |
|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| 1976 | 183 | 5.7 | 79 | 2.4 | 1562 | 48.4 | 34043 | 1054.6 |
| 1977 | 151 | 4.6 | 73 | 2.2 | 1736 | 53.1 | 33632 | 1027.9 |
| 1978 | 155 | 4.7 | 102 | 3.1 | 1796 | 54.2 | 33794 | 1019.7 |
| 1979 | 193 | 5.7 | 120 | 3.6 | 1880 | 55.8 | 33771 | 1002.7 |
| 1980 | 216 | 6.4 | 84 | 2.5 | 1713 | 50.4 | 33472 | 984.2 |
| 1981 | 223 | 6.5 | 72 | 2.1 | 1717 | 49.9 | 32929 | 956.4 |
| 1982 | 241 | 6.9 | 67 | 1.9 | 1630 | 46.8 | 32457 | 932.7 |
| 1983 | 282 | 8.0 | 62 | 1.0 | 1593 | 45.5 | 32976 | 941.1 |
| 1984 | 232 | 6.6 | 67 | 1.9 | 1436 | 40.7 | 32076 | 908.9 |
| 1985 | 276 | 7.8 | 65 | 1.8 | 1488 | 42.0 | 33213 | 938.2 |
| 1986 | 283 | 8.0 | 83 | 2.3 | 1539 | 43.5 | 33630 | 949.7 |
| 1987 | 245 | 6.9 | 71 | 2.0 | 1489 | 42.0 | 31413 | 885.6 |
| 1988 | 266 | 7.5 | 68 | 1.9 | 1427 | 40.4 | 31580 | 894.4 |
| 1989 | 278 | 7.9 | 92 | 2.6 | 1524 | 43.4 | 32111 | 914.8 |
| 1990 | 334 | 9.5 | 48 | 1.4 | 1502 | 42.8 | 31370 | 894.8 |
| 1991 | 346 | 9.8 | 38 | 1.1 | 1455 | 41.3 | 31305 | 887.8 |
| 1992 | 363 | 10.2 | 22 | 0.6 | 1363 | 38.3 | 30931 | 870.1 |
| 1993 | 324 | 9.1 | 19 | 0.5 | 1377 | 38.5 | 32148 | 890.1 |
| 1994 | 390 | 10.9 | 14 | 0.4 | 1447 | 40.4 | 30948 | 863.0 |
| 1995 | 385 | 10.7 | 5 | 0.1 | 1454 | 40.4 | 32259 | 895.8 |
| 1996 | 399 | 11.0 | 11 | 0.0 | 1524 | 42.0 | 31728 | 874.9 |
| 1997* | 444 | 12.1 | 14 | 0.4 | 1524 | 41.6 | 31605 | 863.3 |
| 1998* | 504 | 13.6 | 43 | 1.2 | 1747 | 47.2 | 31352 | 846.2 |
| 1999* | 439 | 11.7 | 46 | 1.2 | 1679 | 44.8 | 31683 | 846.0 |

*these data relate to deaths registered in these years

Note: Rates are calculated as per 100,000 population

• Data source National Suicide Review Group

## Table 1b. Suicide, undetermined death, death by external causes, death by all causes, 1976-1999 (Males)

| Year | Suicide | | Undetermined death | | Death by external causes | | Death by all causes | |
|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| 1976 | 129 | 7.9 | 57 | 3.5 | 1003 | 61.8 | 18465 | 1137.7 |
| 1977 | 98 | 6.0 | 46 | 2.8 | 1068 | 64.9 | 18297 | 1112.3 |
| 1978 | 100 | 6.0 | 70 | 4.2 | 1152 | 69.1 | 18442 | 1107.0 |
| 1979 | 145 | 8.6 | 81 | 4.8 | 1917 | 77.8 | 18603 | 1104.1 |
| 1980 | 143 | 8.4 | 61 | 3.6 | 1118 | 65.4 | 18230 | 1066.7 |
| 1981 | 158 | 9.1 | 51 | 2.9 | 1181 | 68.3 | 18068 | 1045.0 |
| 1982 | 178 | 10.2 | 50 | 2.9 | 1123 | 64.3 | 17755 | 1016.9 |
| 1983 | 202 | 11.5 | 47 | 2.7 | 1062 | 60.5 | 18026 | 1026.5 |
| 1984 | 164 | 9.3 | 46 | 2.6 | 973 | 55.1 | 17485 | 989.5 |
| 1985 | 216 | 12.2 | 45 | 2.5 | 1019 | 57.5 | 18201 | 1027.7 |
| 1986 | 217 | 12.3 | 57 | 3.2 | 1039 | 58.7 | 18313 | 1034.6 |
| 1987 | 185 | 10.5 | 55 | 3.1 | 990 | 55.9 | 17002 | 960.6 |
| 1988 | 195 | 11.1 | 49 | 2.8 | 961 | 54.6 | 16980 | 965.3 |
| 1989 | 213 | 12.2 | 64 | 3.7 | 1049 | 60.1 | 17058 | 978.1 |
| 1990 | 251 | 14.4 | 33 | 1.9 | 1009 | 57.9 | 16828 | 965.5 |
| 1991 | 283 | 16.1 | 31 | 1.8 | 1025 | 58.5 | 16603 | 947.1 |
| 1992 | 304 | 17.2 | 19 | 1.1 | 981 | 55.7 | 16516 | 934.2 |
| 1993 | 259 | 14.6 | 15 | 0.8 | 937 | 52.7 | 17035 | 958.1 |
| 1994 | 300 | 16.8 | 10 | 0.6 | 1019 | 57.2 | 16338 | 916.3 |
| 1995 | 310 | 17.3 | 3 | 0.2 | 1025 | 57.3 | 17075 | 955.0 |
| 1996 | 335 | 18.6 | 9 | 0.5 | 1108 | 61.6 | 16672 | 926.2 |
| 1997* | 363 | 20.0 | 11 | 0.6 | 1072 | 59.0 | 16461 | 905.9 |
| 1998* | 421 | 22.9 | 30 | 1.6 | 1249 | 67.9 | 16482 | 896.2 |
| 1999* | 349 | 18.8 | 29 | 1.6 | 1177 | 63.3 | 16480 | 886.5 |

*these data relate to deaths registered in these years

- Data source National Suicide Review Group

## Table 1c. Suicide, undetermined death, death by external causes, death by all causes, 1976-1999 (Females)

| Year | Suicide | | Undetermined death | | Death by external causes | | Death by all causes | |
|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| 1976 | 54 | 3.4 | 22 | 1.4 | 559 | 34.8 | 15578 | 970.6 |
| 1977 | 53 | 3.3 | 27 | 1.7 | 668 | 41.1 | 15335 | 942.5 |
| 1978 | 55 | 3.3 | 32 | 1.9 | 644 | 39.1 | 15352 | 931.6 |
| 1979 | 48 | 2.9 | 39 | 2.3 | 563 | 33.6 | 15078 | 900.2 |
| 1980 | 73 | 4.3 | 23 | 1.3 | 595 | 35.2 | 15242 | 900.8 |
| 1981 | 65 | 3.8 | 21 | 1.2 | 536 | 31.3 | 14867 | 867.0 |
| 1982 | 63 | 3.6 | 17 | 1.0 | 507 | 29.2 | 14702 | 847.9 |
| 1983 | 80 | 4.6 | 15 | 0.9 | 531 | 30.4 | 14950 | 855.3 |
| 1984 | 68 | 3.9 | 21 | 1.2 | 463 | 26.3 | 14591 | 828.1 |
| 1985 | 60 | 3.4 | 20 | 1.1 | 469 | 26.5 | 15012 | 848.6 |
| 1986 | 66 | 3.7 | 26 | 1.5 | 500 | 28.2 | 15317 | 864.9 |
| 1987 | 60 | 3.4 | 16 | 0.9 | 499 | 28.1 | 14411 | 811.4 |
| 1988 | 71 | 4.0 | 19 | 1.1 | 466 | 26.3 | 14600 | 823.9 |
| 1989 | 65 | 3.7 | 28 | 1.6 | 475 | 26.9 | 15053 | 852.4 |
| 1990 | 83 | 4.7 | 15 | 0.9 | 493 | 28.0 | 14542 | 824.8 |
| 1991 | 63 | 3.6 | 7 | 0.4 | 430 | 24.3 | 14702 | 829.7 |
| 1992 | 59 | 3.3 | 3 | 0.2 | 379 | 21.2 | 14415 | 807.1 |
| 1993 | 65 | 3.6 | 4 | 0.2 | 440 | 24.5 | 15113 | 841.5 |
| 1994 | 90 | 5.0 | 4 | 0.2 | 428 | 23.7 | 14610 | 810.3 |
| 1995 | 75 | 4.1 | 2 | 0.1 | 429 | 23.7 | 15184 | 837.5 |
| 1996 | 64 | 3.5 | 2 | 0.1 | 416 | 22.8 | 15051 | 824.3 |
| 1997* | 81 | 4.4 | 3 | 0.2 | 452 | 24.5 | 15144 | 821.7 |
| 1998* | 83 | 4.4 | 13 | 0.7 | 498 | 26.7 | 14870 | 796.9 |
| 1999* | 90 | 4.8 | 17 | 0.9 | 502 | 26.6 | 15203 | 806.1 |

*these data relate to deaths registered in these years

• Data source National Suicide Review Group

## Table 2. Suicides registered between 1995 and 1999 by age and gender

| Age group | Persons | | Males | | Females | |
|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate |
| 0-4yrs | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| 5-9yrs | 1 | 0.1 | 1 | 0.1 | 0 | 0.0 |
| 10-14yrs | 20 | 1.3 | 17 | 2.1 | 3 | 0.4 |
| 15-19yrs | 191 | 11.2 | 156 | 17.8 | 35 | 4.2 |
| 20-24yrs | 332 | 22.1 | 292 | 38.3 | 40 | 5.1 |
| 25-29yrs | 263 | 19.5 | 230 | 34.0 | 33 | 4.9 |
| 30-34yrs | 235 | 17.9 | 192 | 29.9 | 43 | 6.4 |
| 35-39yrs | 222 | 17.2 | 179 | 28.1 | 43 | 6.6 |
| 40-44yrs | 218 | 17.8 | 179 | 29.3 | 39 | 6.4 |
| 45-49yrs | 177 | 15.5 | 133 | 23.1 | 44 | 7.7 |
| 50-54yrs | 141 | 14.3 | 105 | 21.0 | 36 | 7.4 |
| 55-59yrs | 112 | 14.2 | 91 | 22.8 | 21 | 5.4 |
| 60-64yrs | 89 | 12.7 | 65 | 18.6 | 24 | 6.8 |
| 65-69yrs | 75 | 11.8 | 59 | 19.3 | 16 | 4.8 |
| 70-74yrs | 45 | 8.0 | 36 | 14.4 | 9 | 2.9 |
| 75-79yrs | 47 | 11.0 | 37 | 20.7 | 10 | 4.0 |
| 80-84yrs | 21 | 7.6 | 18 | 17.3 | 3 | 1.7 |
| 85yrs+ | 11 | 6.0 | 9 | 15.8 | 2 | 1.6 |
| Total | 2200 | 12.0 | 1799 | 19.8 | 401 | 4.3 |

- Data source National Suicide Review Group

## Table 3. Methods used in suicides registered between 1995 and 1999 by age and gender

| | *Age group* | *Poisoning* | *Hanging* | *Drowning* | *Guns* | *Other* |
|---|---|---|---|---|---|---|
| Persons | Under 15 yrs | 2 | 17 | 0 | 2 | 0 |
| | 15-24 yrs | 55 | 292 | 69 | 77 | 30 |
| | 25-44 yrs | 217 | 410 | 190 | 59 | 62 |
| | 45-64 yrs | 117 | 167 | 183 | 33 | 19 |
| | Over 65 yrs | 29 | 75 | 75 | 11 | 9 |
| | Total | 420 | 961 | 517 | 182 | 120 |
| Males | Under 15 yrs | 0 | 16 | 0 | 2 | 0 |
| | 15-24 yrs | 32 | 258 | 56 | 74 | 28 |
| | 25-44 yrs | 171 | 367 | 145 | 48 | 49 |
| | 45-64 yrs | 79 | 147 | 125 | 30 | 13 |
| | Over 65 yrs | 22 | 69 | 50 | 11 | 7 |
| | Total | 304 | 857 | 376 | 165 | 97 |
| Females | Under 15 yrs | 2 | 1 | 0 | 0 | 0 |
| | 15-24 yrs | 23 | 34 | 13 | 3 | 2 |
| | 25-44 yrs | 46 | 43 | 45 | 11 | 13 |
| | 45-64 yrs | 38 | 20 | 58 | 3 | 6 |
| | Over 65 yrs | 7 | 6 | 25 | 0 | 2 |
| | Total | 116 | 104 | 141 | 17 | 23 |

• Data source National Suicide Review Group

## Table 4. Suicides registered in each Health Board between 1995 and 1999 by age and gender

| Health Board | Age group | Persons | | Males | | Females | |
|---|---|---|---|---|---|---|---|
| | | 1994-98 | 1995-99 | 1994-98 | 1995-99 | 1994-98 | 1995-99 |
| Eastern (ERHA) | Under 15 yrs | 4 | 6 | 4 | 6 | 0 | 0 |
| | 15-24 yrs | 143 | 156 | 115 | 128 | 28 | 28 |
| | 25-44 yrs | 278 | 326 | 230 | 258 | 48 | 68 |
| | 45-64 yrs | 115 | 126 | 80 | 87 | 35 | 39 |
| | Over 65 yrs | 38 | 29 | 25 | 19 | 13 | 10 |
| | Total | 578 | 643 | 454 | 498 | 124 | 145 |
| Midland | Under 15 yrs | 2 | 3 | 2 | 3 | 0 | 0 |
| | 15-24 yrs | 29 | 31 | 25 | 26 | 4 | 5 |
| | 25-44 yrs | 40 | 51 | 35 | 45 | 5 | 6 |
| | 45-64 yrs | 31 | 33 | 24 | 25 | 7 | 8 |
| | Over 65 yrs | 11 | 12 | 8 | 10 | 3 | 2 |
| | Total | 113 | 130 | 94 | 109 | 19 | 21 |
| Mid-Western | Under 15 yrs | 3 | 2 | 3 | 2 | 0 | 0 |
| | 15-24 yrs | 40 | 39 | 37 | 37 | 3 | 2 |
| | 25-44 yrs | 75 | 81 | 65 | 71 | 10 | 10 |
| | 45-64 yrs | 49 | 55 | 37 | 41 | 12 | 14 |
| | Over 65 yrs | 19 | 17 | 12 | 11 | 7 | 6 |
| | Total | 186 | 194 | 154 | 162 | 32 | 32 |
| North-Eastern | Under 15 yrs | 1 | 0 | 1 | 0 | 0 | 0 |
| | 15-24 yrs | 50 | 54 | 43 | 46 | 7 | 8 |
| | 25-44 yrs | 65 | 74 | 54 | 63 | 11 | 11 |
| | 45-64 yrs | 33 | 42 | 26 | 34 | 7 | 8 |
| | Over 65 yrs | 31 | 25 | 25 | 22 | 6 | 3 |
| | Total | 180 | 195 | 149 | 165 | 31 | 30 |
| North-Western | Under 15 yrs | 0 | 0 | 0 | 0 | 0 | 0 |
| | 15-24 yrs | 22 | 26 | 19 | 24 | 3 | 2 |
| | 25-44 yrs | 46 | 42 | 38 | 38 | 8 | 4 |
| | 45-64 yrs | 32 | 40 | 26 | 33 | 6 | 7 |
| | Over 65 yrs | 9 | 9 | 5 | 6 | 4 | 3 |
| | Total | 109 | 117 | 88 | 101 | 21 | 16 |
| South-Eastern | Under 15 yrs | 5 | 5 | 3 | 3 | 2 | 2 |
| | 15-24 yrs | 62 | 61 | 55 | 53 | 7 | 8 |
| | 25-44 yrs | 107 | 118 | 91 | 100 | 16 | 18 |
| | 45-64 yrs | 64 | 62 | 51 | 52 | 13 | 10 |
| | Over 65 yrs | 27 | 30 | 22 | 25 | 5 | 5 |
| | Total | 265 | 276 | 222 | 233 | 43 | 43 |
| Southern | Under 15 yrs | 5 | 5 | 4 | 4 | 1 | 1 |
| | 15-24 yrs | 86 | 94 | 81 | 88 | 5 | 6 |
| | 25-44 yrs | 177 | 173 | 150 | 144 | 27 | 29 |
| | 45-64 yrs | 106 | 104 | 71 | 72 | 35 | 32 |
| | Over 65 yrs | 38 | 39 | 30 | 30 | 8 | 9 |
| | Total | 412 | 415 | 336 | 338 | 76 | 77 |
| Western | Under 15 yrs | 1 | 0 | 1 | 0 | 0 | 0 |
| | 15-24 yrs | 55 | 62 | 46 | 46 | 9 | 16 |
| | 25-44 yrs | 72 | 73 | 60 | 61 | 12 | 12 |
| | 45-64 yrs | 61 | 57 | 51 | 50 | 10 | 7 |
| | Over 65 yrs | 30 | 38 | 24 | 36 | 6 | 2 |
| | Total | 219 | 230 | 182 | 193 | 37 | 37 |

• Data source National Suicide Review Group

TABLE 1

NUMBER OF DEATHS FROM SUICIDE PER 100,000 POPULATION BY HEALTH BOARD AREA AND COUNTY 1997 TO 2000

| Health Board Area and County | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|
| **EASTERN** | | | | |
| Dublin | 9.8 | 11.2 | 9.5 | 10.1 |
| Kildare | 14.0 | 8.7 | 4.3 | 9.2 |
| Wicklow | 13.5 | 11.4 | 21.7 | 6.5 |
| **Total Eastern** | **10.5** | **10.9** | **9.9** | **9.8** |
| **MIDLAND** | | | | |
| Laois | 9.4 | 22.2 | 5.5 | 5.4 |
| Longford | 6.6 | 3.3 | 16.1 | 9.5 |
| Offaly | 10.1 | 14.9 | 11.5 | 25.9 |
| Westmeath | 6.3 | 17.0 | 16.9 | 12.1 |
| **Total Midland** | **8.2** | **15.7** | **12.3** | **14.0** |
| **MID-WESTERN** | | | | |
| Clare | 10.5 | 14.6 | 13.4 | 6.1 |
| Limerick | 10.8 | 13.0 | 16.4 | 16.2 |
| Tipperary NR | 12.0 | 13.5 | 8.4 | 18.1 |
| **Total Mid-Western** | **10.9** | **13.6** | **14.1** | **13.6** |
| **NORTH-EASTERN** | | | | |
| Cavan | 20.6 | 18.5 | 9.2 | 5.4 |
| Louth | 12.9 | 14.9 | 14.7 | 8.3 |
| Meath | 11.7 | 9.8 | 8.9 | 10.5 |
| Monaghan | 13.5 | 15.3 | 11.4 | 13.0 |
| **Total North-Eastern** | **13.9** | **13.8** | **11.1** | **9.4** |
| **NORTH-WESTERN** | | | | |
| Donegal | 13.0 | 12.8 | 7.5 | 11.0 |
| Leitrim | 23.7 | 19.6 | 27.1 | 11.5 |
| Sligo | 5.3 | 15.8 | 12.2 | 8.5 |
| **Total North-Western** | **12.2** | **14.4** | **11.1** | **10.4** |
| **SOUTH-EASTERN** | | | | |
| Carlow | 23.8 | 11.8 | 9.3 | 2.3 |
| Kilkenny | 7.9 | 13.0 | 19.3 | 13.9 |
| Tipperary SR | 11.8 | 20.8 | 11.6 | 12.7 |
| Waterford | 18.8 | 9.3 | 15.3 | 8.1 |
| Wexford | 19.9 | 13.1 | 13.9 | 15.6 |
| **Total South-Eastern** | **16.2** | **13.5** | **14.4** | **11.5** |

| | | | | |
|---|---|---|---|---|
| **SOUTHERN** | | | | |
| Cork | 19.3 | 18.6 | 13.1 | 10.9 |
| Kerry | 13.4 | 22.5 | 12.3 | 14.4 |
| **Total Southern** | **17.9** | **19.5** | **12.9** | **11.8** |
| WESTERN | | | | |
| Galway | 17.3 | 15.0 | 11.3 | 11.6 |
| Mayo | 14.2 | 7.9 | 15.7 | 8.6 |
| Roscommon | 13.4 | 13.2 | 7.5 | 11.0 |
| **Total Western** | **15.7** | **12.5** | **12.1** | **10.6** |
| **Grand Total** | **13.1** | **13.6** | **11.7** | **10.9** |

*Note: Figures for 1998 to 2000 are provisional.* Source: Central Statistics Office.

TABLE 2

NUMBER OF DEATHS FROM SUICIDE BY AGE GROUP
1997 TO 2000

| Age Group | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|
| 0-9 | 0 | 0 | 0 | 1 |
| 10-19 | 41 | 53 | 39 | 46 |
| 20-29 | 137 | 152 | 103 | 114 |
| 30-39 | 101 | 100 | 84 | 78 |
| 40-49 | 76 | 87 | 89 | 66 |
| 50-59 | 59 | 57 | 63 | 53 |
| 60-69 | 38 | 35 | 37 | 35 |
| 70-79 | 23 | 18 | 12 | 17 |
| 80 years and over | 3 | 2 | 12 | 3 |
| **Total** | **478** | **504** | **439** | **413** |

*Note: Figures for 1998 to 2000 are provisional.*

Source: Central Statistics Office.

## TABLE 3
## NUMBER OF DEATHS FROM SUICIDE BY HEALTH BOARD AREA AND COUNTY, 1997 TO 2000

| Health Board Area and County | 1997 | | | 1998 | | | 1999 | | | 2000 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| **EASTERN** | | | | | | | | | | | | |
| Dublin | 85 | 20 | 105 | 98 | 23 | 121 | 69 | 35 | 104 | 91 | 21 | 112 |
| Kildare | 16 | 3 | 19 | 12 | 0 | 12 | 5 | 1 | 6 | 9 | 4 | 13 |
| Wicklow | 13 | 1 | 14 | 10 | 2 | 12 | 20 | 3 | 23 | 6 | 1 | 7 |
| **Total Eastern** | **114** | **24** | **138** | **120** | **25** | **145** | **94** | **39** | **133** | **106** | **26** | **132** |
| **MIDLAND** | | | | | | | | | | | | |
| Laois | 4 | 1 | 5 | 10 | 2 | 12 | 3 | 0 | 3 | 2 | 1 | 3 |
| Longford | 2 | 0 | 2 | 1 | 0 | 1 | 5 | 0 | 5 | 2 | 1 | 3 |
| Offaly | 4 | 2 | 6 | 8 | 1 | 9 | 5 | 2 | 7 | 12 | 4 | 16 |
| Westmeath | 4 | 0 | 4 | 9 | 2 | 11 | 10 | 1 | 11 | 7 | 1 | 8 |
| **Total Midland** | **14** | **3** | **17** | **28** | **5** | **33** | **23** | **3** | **26** | **23** | **7** | **30** |
| **MID-WESTERN** | | | | | | | | | | | | |
| Clare | 7 | 3 | 10 | 13 | 1 | 14 | 10 | 3 | 13 | 5 | 1 | 6 |
| Limerick | 12 | 6 | 18 | 19 | 3 | 22 | 24 | 4 | 28 | 25 | 3 | 28 |
| Tipperary NR | 7 | 0 | 7 | 7 | 1 | 8 | 3 | 2 | 5 | 7 | 4 | 11 |
| **Total Mid-Western** | **26** | **9** | **35** | **39** | **5** | **44** | **37** | **9** | **46** | **37** | **8** | **45** |
| **NORTH-EASTERN** | | | | | | | | | | | | |
| Cavan | 11 | 0 | 11 | 10 | 0 | 10 | 5 | 0 | 5 | 2 | 1 | 3 |
| Louth | 8 | 4 | 12 | 9 | 5 | 14 | 12 | 2 | 14 | 7 | 1 | 8 |
| Meath | 11 | 2 | 13 | 9 | 2 | 11 | 7 | 3 | 10 | 11 | 1 | 12 |
| Monaghan | 5 | 2 | 7 | 6 | 2 | 8 | 6 | 0 | 6 | 7 | 0 | 7 |
| **Total North-Eastern** | **35** | **8** | **43** | **34** | **9** | **43** | **30** | **5** | **35** | **27** | **3** | **30** |
| **NORTH-WESTERN** | | | | | | | | | | | | |
| Donegal | 13 | 4 | 17 | 15 | 2 | 17 | 9 | 1 | 10 | 12 | 3 | 15 |
| Leitrim | 5 | 1 | 6 | 4 | 1 | 5 | 7 | 0 | 7 | 3 | 0 | 3 |
| Sligo | 2 | 1 | 3 | 8 | 1 | 9 | 6 | 1 | 7 | 5 | 0 | 5 |
| **Total North-Western** | **20** | **6** | **26** | **27** | **4** | **31** | **22** | **2** | **24** | **20** | **3** | **23** |
| **SOUTH-EASTERN** | | | | | | | | | | | | |
| Carlow | 10 | 0 | 10 | 5 | 0 | 5 | 3 | 1 | 4 | 1 | 0 | 1 |
| Kilkenny | 6 | 0 | 6 | 8 | 2 | 10 | 13 | 2 | 15 | 11 | 0 | 11 |
| Tipperary SR | 8 | 1 | 9 | 12 | 4 | 16 | 9 | 0 | 9 | 9 | 1 | 10 |
| Waterford | 13 | 5 | 18 | 9 | 0 | 9 | 10 | 5 | 15 | 7 | 1 | 8 |
| Wexford | 15 | 6 | 21 | 9 | 5 | 14 | 15 | 0 | 15 | 15 | 2 | 17 |
| **Total South-Eastern** | **52** | **12** | **64** | **43** | **11** | **54** | **50** | **8** | **58** | **43** | **4** | **47** |
| **SOUTHERN** | | | | | | | | | | | | |
| Cork | 64 | 18 | 82 | 67 | 13 | 80 | 45 | 12 | 57 | 40 | 8 | 48 |
| Kerry | 16 | 1 | 17 | 24 | 5 | 29 | 14 | 2 | 16 | 17 | 2 | 19 |
| Total Southern | 80 | 19 | 99 | 91 | 18 | 109 | 59 | 14 | 73 | 57 | 10 | 67 |
| Western | | | | | | | | | | | | |
| Galway | 25 | 8 | 33 | 24 | 5 | 29 | 16 | 6 | 22 | 14 | 9 | 23 |
| Mayo | 13 | 3 | 16 | 8 | 1 | 9 | 15 | 3 | 18 | 8 | 2 | 10 |
| Roscommon | 7 | 0 | 7 | 7 | 0 | 7 | 3 | 1 | 4 | 6 | 0 | 6 |
| **Total Western** | **45** | **11** | **56** | **39** | **6** | **45** | **34** | **10** | **44** | **28** | **11** | **39** |
| **Grand Total** | **386** | **92** | **478** | **421** | **83** | **504** | **349** | **90** | **439** | **341** | **72** | **413** |

*Note: Figures for 1998 to 2000 are provisional.*

Source: Central Statistics Office.